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The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION

Indianapolis

The Ten Commandments of Medical Ethics

I—Reverence and Responsibility

REMEMBER the Creator in the days of thy professional youth. Bow reverently before the wondrous human body, sick or well, as thou wouldst before a sacred shrine, conscious of thy high duty; resolved to serve to the best of thy power, whether the patient be white or black, prince or pauper, saint or degenerate.

II—Historic Appreciation

HONOR thy father and thy mother. Likewise give praise to the fathers in medicine whose rich heritage of scientific and clinical truth has been handed down to thee through centuries of patient toil. Hold fast to that which is good, but let not the prejudices coming out of the past, blind thy vision to the newer truths of medical advancement.

—Keeping the faith

THOU SHALT NOT worship the graven images of false practice—of avarice and selfishness which eat at the very heart of medical idealism; of clever artifice or brazen quackery wilyly devious; of erratic isms and cults but half truths, leading the ignorant and tray.

—Inviolable Confidences

THOU SHALT NOT disclose the secrets confided to thy keeping by trusting patients, unless they be of criminal or treasonable import. Nor shalt thou abuse the intimacy accorded to thee by women, which becomes a professional moral obligation thou shouldst hold inviolate.

—The Sanctity of Life

THOU SHALT NOT hazard life unwarrantably. Neither shalt thou shrink before the obvious perils of duty when life is at stake. The unborn shalt thou not destroy, except after due consultation it is deemed advisable for the larger saving of life. Suffer not death to come through neglect in the routine care of the sick, nor from failure in reading, study and counsel, to gain the greatest benefit for the patient.

VI—Professional Cooperation

THOU SHALT NOT bear false witness against a worthy professional brother, but seek ever to protect his reputation from calumnious attack by misinterpreting laymen. Of thy knowledge give him unstintingly, counselling and cooperating for medical progress.

VII—Gentlemanly Conduct

THOU SHALT NOT prate of cases, nor countenance unseemly boasting of thy achievements in the lay press. Always a gentleman, let thy conduct be reserved but without cowardice; courteous but without flattery; dignified but of warm heart; tender in ministrations but firm in command; clean of body, speech and mind.

VIII—Honesty in Business

THOU SHALT NOT steal; neither shalt thou make extortionate charges nor deceive by the secret division of fees. Let thy service be worthy of hire for which exact fair compensation, but by open methods, with conscience void of offense toward thy fellowman.

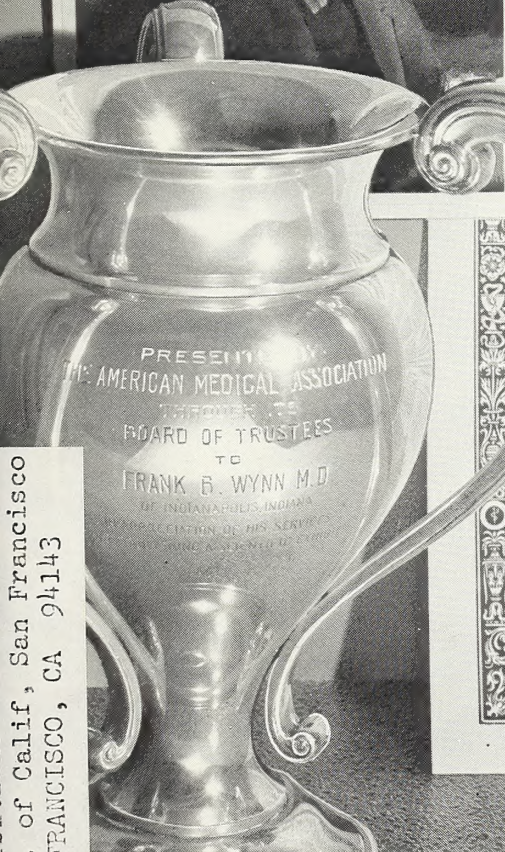
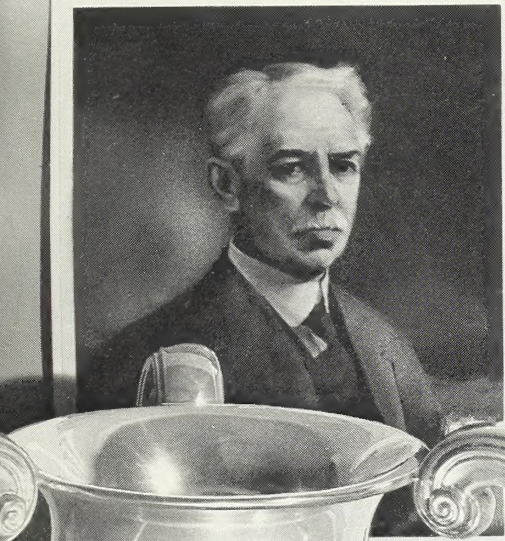
IX—Obligation to One's Own

TAKE HEED of the morrow for the sake of thine own flesh and blood. Therefore shalt thou keep orderly accounts, collecting from the full-handed just recompense for service rendered. To the poor and to the families of deserving colleagues thou shouldst account it a privilege to render faithful attention.

X—Personal and Public Service

REMEMBER thou art thy brother's keeper—physically in the measures advised for the prevention, alleviation or healing of disease; spiritually in the cheer thou bringest to heavy hearts and the courage thou givest to halting steps. So walking upright before man, mayest thou shew thyself approved unto God. Thus journeying toward life's end, if not signing with the Psalmist, "My cup runneth over," thou wilt at least be sustained by the reflections of "A workman who needeth not be ashamed."

Frank B. Wynn

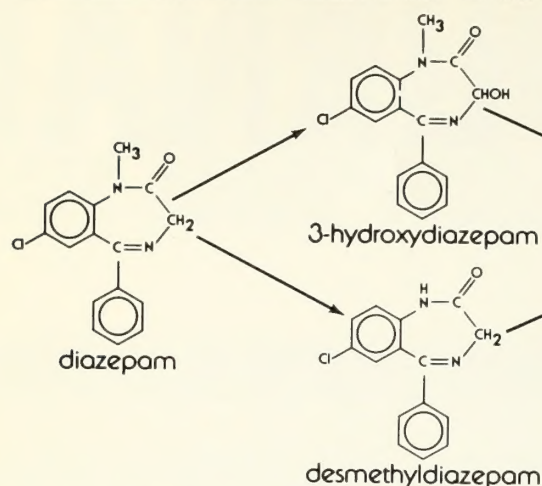


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to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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MEDICAL MUSEUM NOTES



THE cover of this issue of *The Journal* again features Frank B. Wynn, M.D., this time symbolizing his role in founding what is now the Scientific Exhibit Program of the annual meeting of the American Medical Association.

Among the many organizations to which Dr. Wynn belonged is the Mazamas, a western nature group whose principal activity is mountain climbing. Their motto: NESIKA KLATAWA SAHALE, from the Chinook, meaning "We climb high," applies particularly to Dr. Wynn because he climbed high in all his endeavors—whether climbing mountains, practicing medicine or engaging in any of his numerous activities and interests. He climbed high because he aimed high. His *Ten Commandments of Medical Ethics* reveals the essence of his medical philosophy.

Pictured on the cover is the silver loving cup given to Dr. Wynn by the American Medical Association in recognition of his brain child, the 1898 and 1899 Pathology Exhibits of the Indiana State Medical Association, which, when shown at the AMA convention in 1899 at Columbus, Ohio, became an instant success, and has since played an important part in the annual meetings of the AMA.

In the background is the Ashby portrait of Wynn which was exhibited at the 1974 AMA meeting on the occasion of the 75th Anniver-

sary of the Scientific Exhibit, and which was featured on the cover of *The Journal of the Indiana State Medical Association* in October 1972, in commemoration of the 50th year of Dr. Wynn's death.

Also in the background is a copy of Dr. Wynn's *Ten Commandments of Medical Ethics*. For many years graduates of Indiana University School of Medicine received an elegant copy for framing from the Pittman-Moore Company. This continued into the 1950s. A re-issue was done several years ago by Dow Chemical Company (successor to Pittman-Moore) for a program about Dr. Wynn by the John Shaw Billings History of Medicine Society at I.U.M.C.

The silver loving cup was recently presented to the Museum by Barbara and Mrs. Louise Wynn of Monterey, Calif. Barbara is the granddaughter of Dr. Frank Wynn and the daughter of Louise and Dr. James Wynn.

James Wynn, the only son of Dr. and Mrs. Frank Wynn, graduated from Indiana University School of Medicine in 1919. He served an internship at the Robert Long Hospital and did postgraduate work at the Peter Bent Brigham Hospital at Boston, Mass., and at Johns Hopkins University. He returned to Indiana University, but he contracted tuberculosis and moved to Colorado for his health, where he died in 1931 at the age of 35.

In addition to the loving cup, Barbara and Mrs. Wynn also gave a silver tray that had been presented to Dr. Frank Wynn by his first patient, on which is mounted the first gold dollar he received as a fee for his services.

The spirit of Frank Wynn, M.D., still lives at Indiana University School of Medicine, where he taught; at the Indiana State Medical Association, where he served in various ways, including president in 1915; at the Indiana Historical Society, where he also served in various ways, including chairman of the Centennial Commission in 1915-

1916; and in the Old Pathology Building, where he (with three other notables) initiated the teaching program there. His services to these and other groups was monumental, revealing an attitude of "Nesika klatawa sahalé" in all he undertook.

Dr. Wynn was a student of history, especially of medical history. He advocated the preservation of the artifacts of the state's medical heritage by the ISMA and its members. He included such material in his 1898 and 1899 exhibits for the ISMA. He never returned to this theme (in writing, at least) after the AMA took over the Pathology Exhibit, apparently because he remained an active participant in preparing the annual pathology programs, and this limited his time for other activities. His role with the Centennial Commission, however, reveals his continued interest in Indiana history.

Dr. Frank Wynn lost his life while climbing Mt. Siyeh in Glacier National Park July 27, 1922. An adjacent peak is named for him.

CHARLES A. BONSETT, M.D.
6133 East 54th Place
Indianapolis 46226



DOCTOR FRANK B. WYNN
Physician

CARICATURE of Dr. Frank Wynn indicating mountain climbing and Centennial activities (1916).

THE INDIANA STATE MEDICAL ASSOCIATION

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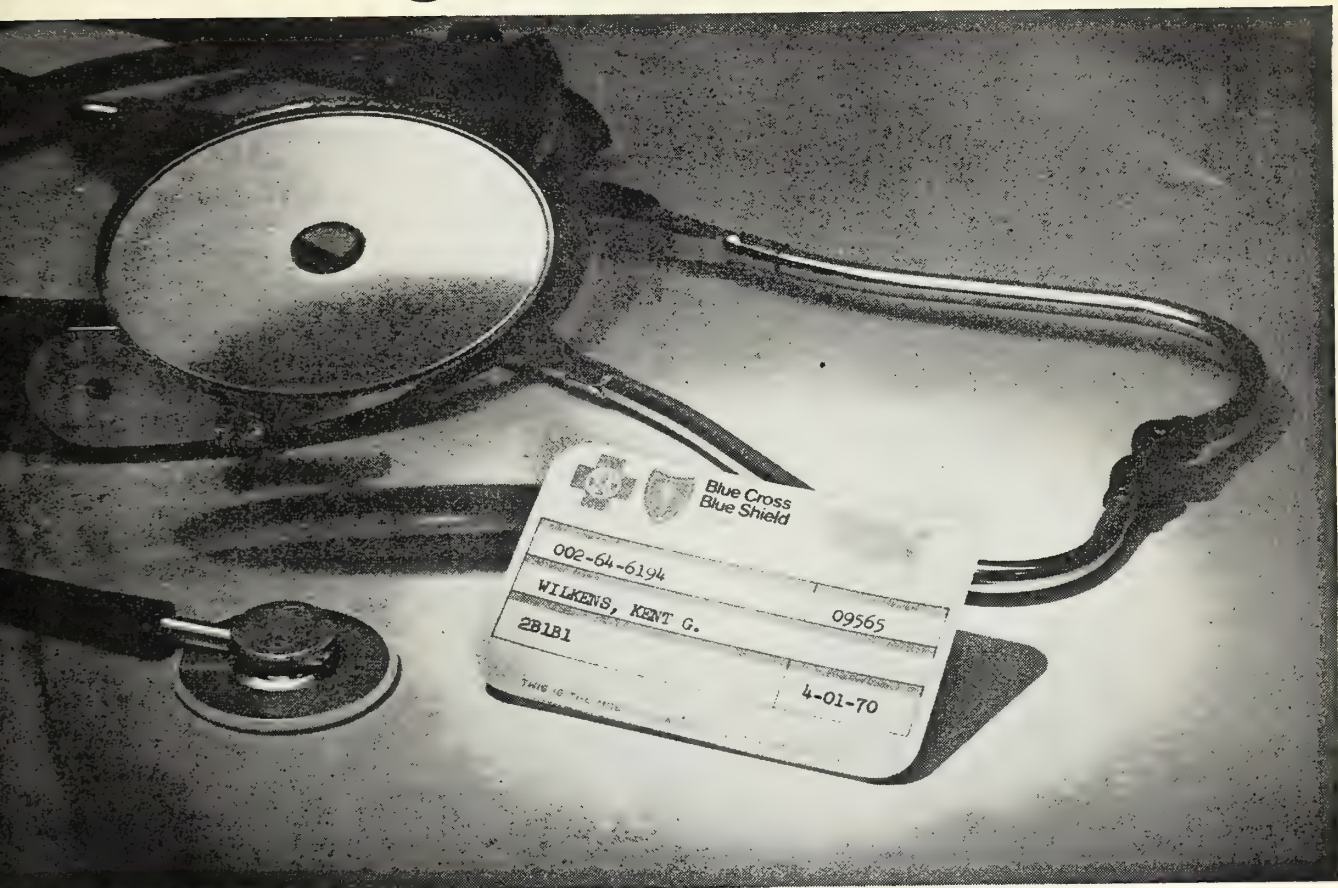
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3.	Claude J. Meyer, Jeffersonville	Charles X. McCalla, Paoli	Sept. 17-18
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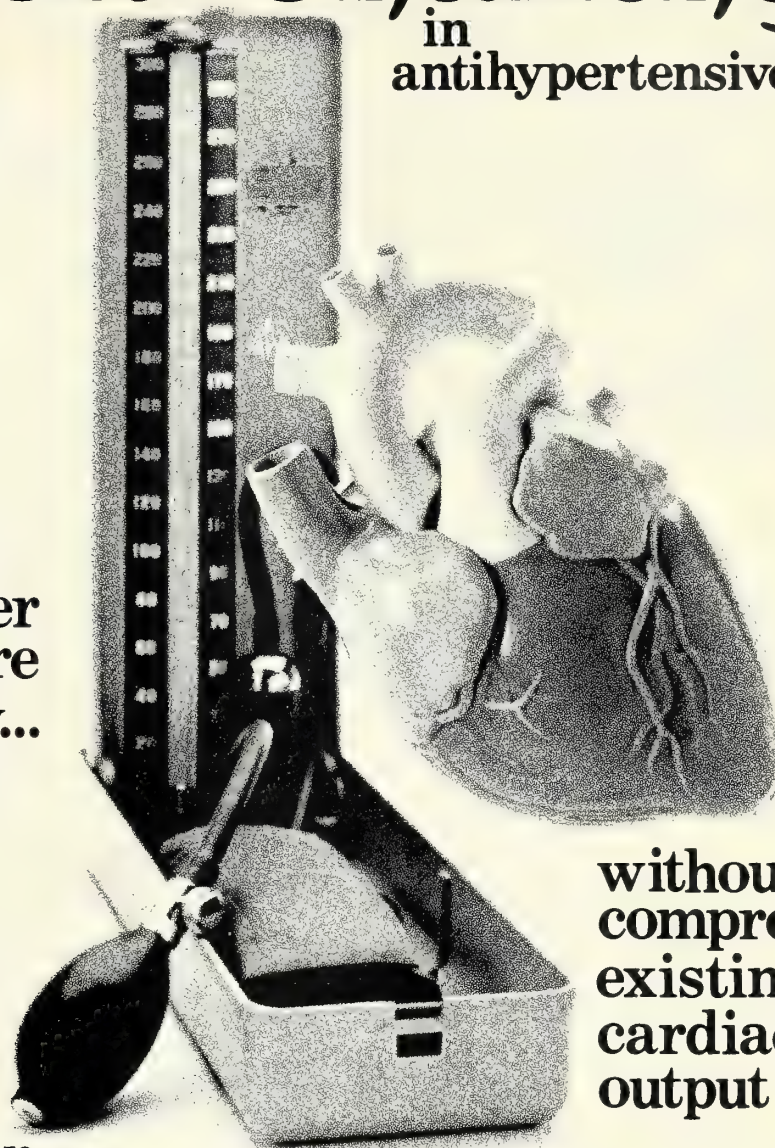
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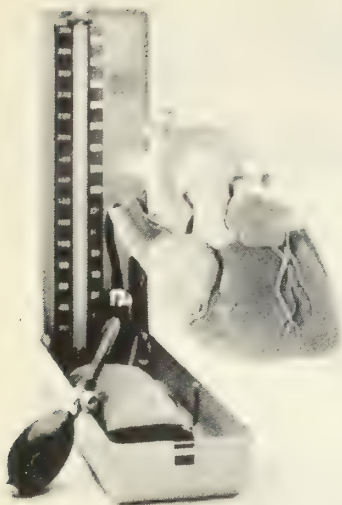
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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatulence, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to *The Journal* on the first of each month preceding month of issue.

THE AMERICAN MEDICAL ASSOCIATION has assailed the government's release of the names of 995 physicians who last year received \$100,000 or more from the Medicaid program, terming the action "nothing less than an attempt at guilt by innuendo."

"It simply makes a tough practice tougher for the thousands of dedicated, honest ghetto physicians," declared James Sammons, M.D., executive vice president of the AMA.

A total of 2,533 Medicaid providers, including dentists, pharmacies and laboratories as well as physicians, was released by the Social and Rehabilitation Service (SRS) of the Health, Education, and Welfare Department. The Agency said the list was requested under the Freedom of Information Act by news media and others. Under the Act, according to the Agency, the information must be provided.

"The fact that these medical providers received the stated amounts from the Medicaid program should not be construed as any evidence of wrongdoing, nor do amounts listed necessarily represent 'earnings' or 'profits,'" SRS spokesman said, adding that it had no information as to the size of staffs employed by the individual doctors, or the number of separate offices they may maintain.

In addition to the 995 physicians, there were 312 dentists, 127 labs, and 1,099 pharmacies on the list released by HEW. The physicians included 542 individual practices and 453 group practices.

States with the largest numbers of physicians on the list were California, 300; Illinois, 144; New York, 113; Michigan, 83; Texas, 62; Ohio, 41; and New Jersey, 28. The names and addresses of all physicians, including those in the group practices, were contained in the massive, inch-thick document.

AMA's Dr. Sammons asked, "Does HEW think these doctors are guilty of fraud? Then let HEW say so. Does HEW think they are guilty of violation of ethics? Then let them give us the names and we will investigate."

"The AMA favors prosecution to the fullest extent of the law of any person—physician or otherwise—who defrauds patients or the government," Dr. Sammons said, "But we are tired of doctors being made the whipping boy by publicity-seeking bureaucrats and politicians. If they want to clean up Medicaid and Medicare let them go after the Medicaid Mill and nursing home operators who prosper in every major city with political protection. That's the root of the corruption and the fraud and abuse."

"This releasing of names is nothing less than an attempt at guilt by innuendo. It simply makes a tough practice tougher for the thousands of dedicated, honest ghetto physicians. If HEW wants to drive medical care out of the ghetto completely, it has certainly hit upon a highly effective method."

PATIENT PACKAGE INSERTS for almost all drugs, one of the major demands of the consumer movement, with their attendant problems and concerns, were discussed at a two-day

symposium here recently. The session was sponsored by the AMA, the Drug Information Association, the Food and Drug Administration and the Pharmaceutical Manufacturers Association.

The patient insert should not be confused with the package insert. Years ago Congress approved the requirements for the package insert for prescription drugs, apparently in the mistaken belief much of this information would get to the patient. Most of it went to pharmacists; none was required to be given to patients.

There were hearings in the last Congress on legislation introduced in House and Senate aimed at providing patients, with certain exceptions, insert information on the prescription drugs they receive.

FDA Commissioner Alexander Schmidt, M.D., told the symposium the consumer has a right to know that a high proportion of Americans either do not understand the prescription instructions or do not follow them," Dr. Schmidt said. He contended there is a lack of effective communication often between physician and patient on drug information.

The information supplied patients must not be as detailed as the warnings required in advertising. This would be "an invitation to hypochondria," said Dr. Schmidt. Rather the information should be in plain English, factual, and explain why the drug is being taken, major side-effects to watch out for, and when to report reactions to the physician, according to the FDA Chief.

William Barclay, M.D., AMA group vice president for scientific publications, said carefully prepared information about selected drugs is desirable and could be of service to patients, physicians and pharmacists. However, Dr. Barclay cautioned that there is a clear danger that the disclosure could be so alarming as to discourage use of drugs that are vitally needed.

One of the major questions to be answered is how the insert would be distributed. "Obviously, the physician would rather not have the responsibility of stocking in his office perhaps thousands of brochures," he said.

Of even greater importance, is the liability and other factors involved when physicians in certain cases for the sake of their patients either want no insert provided or want to suggest doses or other information that might run counter to the insert's material.

Dr. Barclay noted that labeling has had little effect on cigarette smoking. He also noted that one of the most powerful drugs available with all sorts of adverse reactions and addiction potential would not be covered by the patient insert—alcohol.

John Adams, Ph.D., vice president of the PMA, said non-prescription drugs contain far more patient informational material than the stronger prescription drugs. However, the patient package insert could cause severe strain on the physician-patient relationship, he said. "An adequate explanation of

Continued on page 14

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Specific information on course location, fees, academic program, faculty, and hotel reservations will be available approximately 2 months before each course date. Please write to address below at that time stating your selection(s). Print name, address, and office phone number.

1977 Regional Schedule

Tulsa, Oklahoma	January 22-23
Birmingham, Alabama	February 5-6
*Lake Tahoe, Nevada	February 11-13
Denver, Colorado	February 19-20
*Tarpon Springs, Florida	March 4-6
Detroit (Southfield), Michigan	March 26-27
New York (Westchester), New York	April 16-17
Houston, Texas	May 15
Hartford, Connecticut	September 10-11
*Lake of the Ozarks, Missouri	September 16-18
Chicago, Illinois	September 24-25
*Hot Springs (Homestead), Virginia	Sept. 30-Oct. 2
*Huron, Ohio	October 7-9

*Honolulu, Hawaii	Oct. 30-Nov. 4
Hershey, Pennsylvania	November 18-19

AMA's 126th Annual Convention

San Francisco, California	June 18-22
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AMA's Winter Scientific Meeting

Miami Beach, Florida	December 10-13
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AMA Spokesmanship Seminars

Chicago, Illinois	August 13-14
(Marriott O'Hare Hotel)	November 12-13

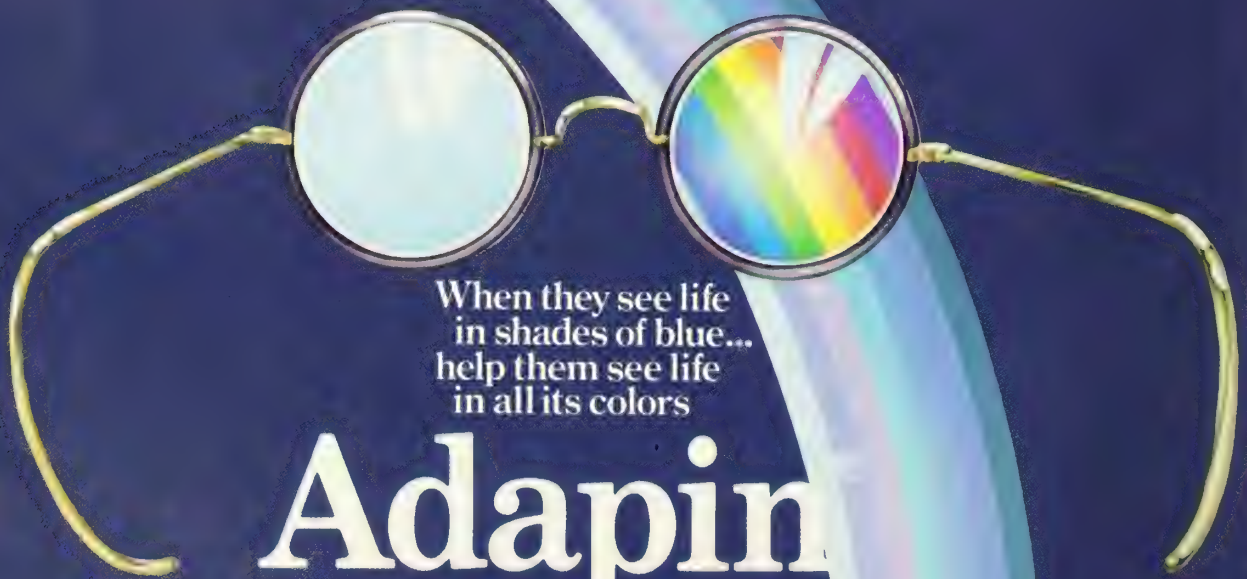
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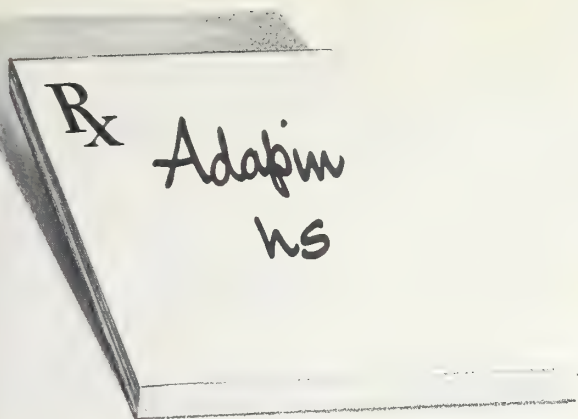
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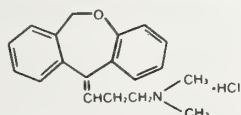
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INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin**.

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—**Adapin** has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin (doxepin hydrochloride)**, gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin**. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin**; therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression:

10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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MONTH IN WASHINGTON

Continued

the risks and benefits might be impossible in a brief description."

Joseph Onek, counsel for the Center for Law and Social Policy, said physicians don't have the time to tell their patients all they need to know about drugs. Patients forget anyway. He suggested that a priority list be made up for the inserts, starting with all drugs used in pregnancy, then tranquilizers and barbiturates.

THE SOCIAL SECURITY ADMINISTRATION is asking the public for help on how much information, including medical data, should be disclosed from Social Security records.

"Social Security needs to change its regulation to make it conform with the Privacy Act, the Freedom of Information Act, and the new Government in the Sunshine Act," a spokesman said.

"An important issue underlying these laws is the basic conflict between the public's right to know and the right of privacy of the people whose records are kept by Social Security," SSA Chief James Cardwell said. "We will need to resolve that conflict in our regulation, and we want the public's help."

Social Security said the revised regulation must address the basic information about an individual collected for purposes of administering the Social Security Act vs. interchange of such information with state or federal agencies to further efficient administration of other benefit programs, or to meet other governmental needs—a further concern is the public's right to know.

What personal information (including the Social Security Number) should be disclosed by SSA without the consent of the individual in the following situations:

- (a) for entitlement or potential entitlement to other local/state/federal benefits or service;
- (b) for investigative or prosecution purposes.

Among other questions posed were whether there should be limitations on disclosure of medical information to third parties and special procedures for disclosing medical information to the subject individual, and to make public fees paid to individual physicians, incorporated individual physicians, and other providers of medical services.

"AIRPLANE PILOTS NEED stricter physician examinations because medically unfit airmen continue to endanger themselves and the public," claims the General Accounting Office (GAO) in a report to Congress.

Most of the criticism was directed at private pilot screening but the GAO said that even commercial pilot tests are often less thorough than those for military pilots, air traffic controllers and foreign civilian pilots.

Better medical examination requirements would be especially helpful in singling out pilots with heart trouble, alcoholism and high blood pressure, the GAO said.

The report suggested there are some 23,000 private pilots "who may represent potential safety problems, including about 12,500 with records of driving (autos) while intoxicated and 200 with physical disabilities which prevent them from driving an automobile," said the GAO.

The GAO, an investigative agency for Congress, proposed that the Federal Aviation Administration be allowed to review data of the National Highway Administration on withdrawal or denial of drivers' licenses for pilots.

Most scheduled U.S. airlines have tougher medical checks than required by federal law, but there is no requirement that the airlines notify the government when pilots with FAA medical certificates flunk their airline physicals, according to the GAO.

The GAO report and the recent publication of several books questioning airline safety and pilot reliability may lead to Congressional hearings in 1977. ◀

When **impotence** due to
androgenic deficiency
is driving them apart



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Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Sickle Cell Anemia Support Services

DORIS H. MERRITT, M.D.
Indianapolis

AS early as 1970, leaders in the Indianapolis black community were concerned with the necessity for identifying and assisting individuals who might be carriers of sickle cell hemoglobin. An outgrowth of this concern was the development of the Indianapolis Sickle Cell Anemia Foundation (ISCAF), a division of Martin Center. The organization recruited a group of volunteers to perform screening and provide a modest amount of education and counseling for individuals found to carry the trait. A grant from the Lilly Endowment and numerous fund raising activities by the ISCAF supported these early efforts.

In 1971 the Indiana General Assembly enacted into law a measure requiring that parents, guardians or other persons having responsibility for, or custody of, children entering school for the first time report whether the child had been tested for sickle cell anemia and, if tested, the results of the test. It should be noted that the law does not require that the test be made but only whether the test has been performed and if so, whether the results are positive for sickle cell anemia.

In 1971 an application in support of an Indianapolis Sickle Cell Center was submitted to the United States Public Health Service. The program was designed to enable the community to work with selected Indiana University Medical School faculty to provide a more definitive screening, education and counseling program for individuals with sickle cell trait and anemia. A year later a comprehensive award was made through the Indiana University Foundation which enabled the merging of university and community services into one Indianapolis Sickle Cell Center.

In 1974 the Indiana General Assembly enacted Public Law 56 directing the Indiana State Board of Health to establish a program for the purpose of providing funds for the prevention, care and treatment of sickle cell anemia and for educational programs concerning the disease. An advisory committee was created by the law to assist the Indiana State Board of Health in its administration. The most significant aspect of the Indiana law was the provision of funds for treatment of individuals with sickle cell anemia. Since only research, screening and counseling were permissible with federal funds, the state award rounded out the Indianapolis program by allowing for the institution of a social services program in conjunction with the Sickle Cell Anemia Parents Club and the Center staff. Now, therefore, a complete range of services is available through the Comprehensive Indian-

apolis Sickle Cell Center at 3549 N. College Ave., Indianapolis 46205. Arrangements for testing samples for hemoglobin S and other sickle cell variants, or referral of patients for education and/or counseling may be made by calling (317) 925-7596.

Physicians who wish to refer children for in depth evaluation may do so by calling or writing to Dr. Arthur Provisor, Sickle Cell Clinic, Riley Hospital for Children, Indianapolis 46202, (317) 264-3431. This clinic, too, is subsidized by a grant from the State Board of Health.

Other referral centers supported by the State are:

Clark County Health Department
1220 Missouri Ave.
Jeffersonville 47130
(812) 282-7521

Northwest Indiana Sickle Cell Foundation, Inc., 35 East 5th Ave.
Gary 46402, (219) 883-0307

Urban League of Madison County
329 W. 12th St., Anderson 46015
(317) 642-4971

The first article which follows this brief account describes the difference between sickle cell anemia and trait and the consequences of sickle cell disease. The second article examines the genetics of sickle cell anemia and trait and shows what can be expected from counseling and how it serves as a therapeutic tool in the total care of patients with sickle cell hemoglobin variants. ◀

This publication was supported in part by a grant for a Sickle Cell Center, PHS HL 15166, and Indiana State Board of Health grants.

Dr. Merritt is dean, research and sponsored programs, Indiana University-Purdue University, Indianapolis 46202, and director of the Indianapolis Sickle Cell Center.

Sickle Cell Anemia—The Disease and Current Directions in Research

ROBERT T. WOODBURN, M.D.
Indianapolis

THE purpose of this paper is to define the clinical problems in sickle cell anemia (SCA) based on the known pathophysiologic alterations of blood viscosity and to discuss briefly current clinical research efforts towards their solution.

Historical Perspective

It was a Chicago physician, J. B. Herrick, who first described sickle cell anemia in 1910.¹ While the autosomal dominant nature of the sickling phenomenon was recognized in 1923,² it was not until 1949 that the recessive inheritance pattern of the anemia was characterized.³ By that time, Pauling had theorized that the sickling phenomenon was a function of an abnormal hemoglobin and proved electrophoretically that normal Hgb was different from that in patients with SCA.⁴ In 1957 Ingram proved by amino acid sequencing that the chemical difference between Hgb A and Hgb S was the substitution of valine for glutamic acid in the 6th position of the beta chain.⁵ In the mid 1960s Perutz and Murray proposed steric protein models to account for the aggregation of deoxy-Hgb S molecules into tactoids resulting in the sickling of red blood cells.^{6,7,8} In a relatively short

time, then, SCA has advanced from a clinical curiosity to a well defined molecular disorder of Hgb.

Genetics

(See companion article)

SCA is inherited as an autosomal

recessive disorder. SCA (SS Hgb) is the homozygous state; sickle cell trait (AS Hgb), the heterozygous or carrier state.

SCA is manifested clinically as described in the body of this paper. Sickle cell trait, except under most unusual circumstances of low oxygen tension, is a totally benign state—a non disease.

Pathophysiology

All clinical manifestations of SCA are directly or indirectly related to intravascular sickle transformation of red cells. Deoxygenation of Hgb S changes its molecular conformation, allowing formation of liquid crystals or tactoids. These distort the cells into the characteristic sickle shape, which causes them to become lodged in the microvasculature.⁹

The presence of sickled red cells increases whole blood viscosity, accentuating stasis in small vessels.^{9,10} Viscosity, even of oxygenated blood from patients with SCA, is elevated because of the presence of the irreversibly sickled cell (ISC).¹¹ In contrast to the reversibly sickled cell, the ISC is a red cell whose Hgb may or may not be aggregated into tactoids, depending upon the state of oxygenation, but whose membrane is permanently rigid and distorted.

ISC may account for up to 25% of circulating red cells in certain

individuals but, interestingly enough, does not seem to correlate with the severity of the disease.¹² Nevertheless, it becomes possible to imagine a vicious cycle whereby increased blood viscosity produces stasis in small vessels which, in turn, leads to greater oxygen extraction from red cells, producing sickling, greater increase in viscosity, local hypoxia and acidosis, and vascular occlusion, sometimes leading to organ and tissue infarction.⁹

The clinical manifestations of SCA can be divided into three categories, each based on certain manifestations of altered blood viscosity; these are: (1) infectious complications (2) sickle cell crises and (3) organ damage and failure.

INFECTIOUS COMPLICATIONS

Acute Life-Threatening Types

Risk of death from infection in patients with SCA is greatest during the first five years of life, primarily due to *Diplococcus pneumoniae*.^{13,14} The typical clinical picture is that of sudden onset of fever without an obvious source of infection in a child who does not look particularly ill, but whose clinical condition deteriorates in 12 to 24 hours to a state of septic shock and death.¹⁴ The reason for this susceptibility to overwhelming pneumococcal sepsis is thought to be related to one or more of the immunological defects observed in patients with SCA.

It is known that at some time during the first year of life splenic function ceases in children with SCA. Even though the spleens of these infants and children are read-

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Dr. Woodburn is medical director of the Indianapolis Sickle Cell Center, Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

ily palpable, they do not visualize on liver-spleen scan using technesium sulphur colloid.¹⁵ This is presumably due to the splenic reticuloendothelial system being overwhelmed with the processing of sickled erythrocytes and/or shunting of blood away from splenic macrophages because of sinusoidal plugging by the deformed cells. Serial liver-spleen scans in newborns with SCA will reveal when functional asplenia occurs. Howell-Jolly bodies, nuclear remnants usually removed from the red cell in the spleen, appear in the peripheral blood at this time and this serves as another measure of splenic function. The functional asplenic state resulting in a high risk for infection is analogous to the problem created by surgical splenectomy in young children. Curiously, after age 5 the increased susceptibility to pneumococcal infection disappears, presumably as a result of specific antibody production by repeated exposures to a variety of serotypes of *Diplococcus pneumoniae*.¹⁴

It has also been shown that a defect in the complement system is present in children with SCA.^{16,17} Opsonization of the pneumococcus is crucial for granulocyte and reticuloendothelial uptake of this encapsulated organism. Specific antibodies can opsonize these organisms, but in individuals who have had no prior exposure and therefore lack specific antibody, the heat labile opsonin system is required for proper opsonization of the pneumococcus. As yet, this abnormality has not been fully characterized, but is believed to be due to a defect in the alternate pathway of complement. The relationship, if any, of this defect to functional asplenia is unclear.¹⁶

In addition, abnormalities in granulocyte function have been described in patients with SCA,¹⁸ but have not been confirmed by others.¹⁹

Currently, many centers are involved in research to further define the immunologic defects in these patients, in order to devise rational

therapy. A multi-institutional study is currently planned to test the effectiveness of multivalent pneumococcal polysaccharide vaccine in children with SCA in the vulnerable age group of 6 months to 5 years. A study utilizing prophylactic antibiotics is currently in progress. Cord blood screening in newborn blacks or certainly in those babies whose parents are known to carry the gene for S Hgb is now clinically appropriate.^{20,21,22} By detecting SS children at birth, the physician will be alerted to their need for special attention. Early cultures, hospitalization and antibiotic therapy for apparently minor febrile illnesses will undoubtedly salvage many from death in early childhood. Certainly, if prophylactic antibiotics and/or pneumococcal vaccine are found to be effective, cord blood screening should become routine.

Chronic Types

Osteomyelitis, particularly that caused by *Salmonella* organisms, occurs with increased frequency in patients with SS Hgb.^{23,24} Mechanisms are poorly understood, but again a reticuloendothelial defect secondary to hemolysis has been proposed.²⁵ Patients have been shown to respond normally to *Salmonella* vaccine demonstrating normal antibody production.²⁶

SICKLE CELL CRISES

Three types of crises occur in SCA: painful, aplastic, and splenic sequestration crises. The painful crisis is the most commonly encountered crisis in clinical practice and occurs in patients of all ages. It is characterized by a rather sudden onset of pain in the extremities, joints, back and abdomen and is often accompanied by fever and leukocytosis. The intensity of pain varies from individual to individual, and even within the same individual during different episodes, but is most often moderate to severe. Widespread intravascular sickling with ischemia and infarction is felt to be responsible for these episodes.²⁷ The triggering mechanism is

unknown in most instances, so that treatment is symptomatic, consisting of analgesics, bed rest, hydration and oxygen. There is current disagreement regarding the necessity to alkalize the blood. However, since acidosis enhances and alkalosis inhibits sickling in vitro, it is not unreasonable to administer bicarbonate to produce a mild metabolic alkalosis.²⁸ Care must be taken to exclude other causes of pain and fever, such as osteomyelitis and other infectious diseases. For severe crises lasting longer than 48-72 hours, limited exchange transfusion, as outlined by Brody et al.²⁹ should be considered.

The aplastic crisis is one of the few indications for transfusion in SCA. It usually occurs during an infectious illness and is due to temporary cessation or reduction in erythropoiesis.^{30,31,32} Folic acid deficiency may play a role. It is probable that these episodes occur in everyone at times, but because of the relatively long life span of normal red blood cells, anemia is not manifest or is mild. In patients with brisk hemolysis, however, marked degrees of anemia can occur in relatively short periods of time. This disorder can be detected in the face of worsening anemia with inappropriately low reticulocyte counts. Support with transfusions and treatment of underlying infection until marrow production resumes is crucial.

Splenic sequestration crises rarely occur in children with SCA. Patients are at risk for this complication between the ages of 9 months and 5 years. After age 5, the spleen becomes progressively smaller because of repeated infarction, with resulting fibrosis, so that by age 6 to 8 it can no longer be palpated. Patients present with severe anemia, vascular collapse and marked splenomegaly. Therapy consists of rapid transfusion of packed red cells. If therapy is begun early enough, a dramatic response is noted, and the spleen diminishes in size over a period of days. There is evidence that patients having one such

episode are at increased risk of having repeated episodes. Therefore, due to the life-threatening nature of these crises, splenectomy should be considered after resolution of the acute crisis. Certainly after two such episodes, splenectomy should be performed.³³

ORGAN DAMAGE AND FAILURE

Over the years of repeated sickling and vascular occlusion, macro- and micro-infarction of vital organs slowly takes its toll. In older SCA patients, problems associated with organ failure come to the clinical forefront and are probably ultimately responsible for the decreased life span of these individuals.³⁴ Ocular abnormalities and retinal detachment are responsible for blindness and point up the need for regular ophthalmologic examination in these patients.³⁵

Chronic pulmonary insults from pneumonia, thrombosis and infarction can result in cor pulmonale.³⁶ Congestive heart failure is not uncommon but exact mechanisms are poorly understood. Hepatomegaly with hepatic dysfunction is commonly encountered, especially in older patients. Autopsy has revealed evidence of hepatic necrosis and cirrhosis, presumably due to sinusoidal occlusion by sickling.^{37,38}

Renal disorders include concentrating defects, papillary necrosis and glomerulopathies, including the nephrotic syndrome and renal vein thrombosis.³⁹ The clinically major skeletal abnormalities are those of

aseptic necrosis of the head of the femur and humerus. Areas of osteosclerosis on bone roentgenograms may be seen representing areas of bone infarction. Skin ulcers, predominantly of the ankle, are common and quite resistant to therapy.

Cerebrovascular thrombosis occurs with increased frequency, is seen mainly in children and young adults, and has a propensity to recur in given individuals.¹⁴ For this reason, a continuous transfusion program for these patients should be considered.

Current Directions in Research

From the foregoing, it can be seen that SCA is truly a multi-system disease, presumably due to the sickle phenomenon which occurs under physiologic conditions. No therapy is presently available that will prevent sickling, but much effort is currently underway to find effective and safe agents that might alter the Hgb S molecule in such a way that sickling would be inhibited and yet maintain molecular function.

Numerous agents have been proposed for use in SCA but none has been shown to be of value when tested in controlled situations. One of the most recently considered agents was urea. Urea in vitro in adequate concentrations was shown not only to inhibit sickling, but also to reverse sickling.⁴⁰ Since urea would, in theory, break the hydrophobic bonds believed to be responsible for sickle hemoglobin tactoid formation, a sound biochemical

basis existed for the use of urea as a desickling agent. However, despite optimistic early reports, a multi-institutional study of urea therapy indicated that urea was not beneficial for treatment of sickle cell painful crises.⁴¹

At about the same time that urea was receiving widespread attention, Cerami and Manning suggested that cyanate, a possible contaminant of commercial urea, was the agent responsible for the anti-sickling effect seen with urea. This led to in vitro studies with cyanate, which did show antisickling activity.⁴² Once again, the early trials have not proven effective in a controlled trial. Investigation of other promising agents such as nitrogen mustards, alkyl ureas and dimethyl adipimide are in very preliminary stages.

Summary

Sickle cell anemia is a genetic disorder of the protein Hgb which, on deoxygenation, distorts the red cell, making it less deformable, and increases blood viscosity. This predisposes these patients to infectious complications, special clinical events called crises, and to irreversible multi-system organ damage. Specific therapy is not yet available, but with ongoing research, more effective nonspecific and, it is hoped, specific therapy directed at alteration of the abnormal Hgb molecule will some day be made available. ◀

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Sickle Hemoglobin and Related Variants: The Role of Genetic Counseling

TERRY REED, Ph.D.
Indianapolis

Introduction

A committee of the American Society of Human Genetics recently identified several areas in which genetic counseling can help an individual or family to 1) comprehend the medical aspect of a given disorder, 2) understand the role of heredity in the disorder and the risk to other family members, 3) become aware of alternatives for dealing with the recurrence risks, 4) allow each individual or family to choose an appropriate course of action, and 5) help with adjustments to the disease and/or recurrence risks.¹ The purpose of the present communication is to indicate the scope of the genetic counseling activities of the Indianapolis Sickle Cell Anemia Center.

Medical Aspects

If an individual has a potentially clinically significant hemoglobinopathy, immediate health problems have priority and genetic aspects assume a secondary role. The varied clinical problems related to sickle cell anemia have been reviewed in the preceding paper.² Individuals and families with little risk of disease related to their hemoglobin type are seen by a genetic counselor rather than the center's medical director. The counselor presents background information regarding the

nature of sickle cell anemia: i.e., the defect is in the red blood cell and, more specifically, the protein hemoglobin, which is the oxygen-carrying pigment of the red cell. Medical information is relayed to develop the understanding that the varied symptoms of sickle cell anemia are the consequences of rigid sickle-shaped red blood cells clogging small capillaries at one or more places in the body.

Inheritance

Providing accurate information regarding inheritance of hemoglobin variants is a major role of the genetic counselor. At the Indianapolis Sickle Cell Center it is the family unit which is emphasized.

Genetic information is contained in the nucleus of cells on microscopic bodies called chromosomes. There are 46 chromosomes (23 pairs) in man. Half of the chromosomes are contributed by each parent.³ Regions of homologous chromosome pairs contain genes (alleles) responsible for production of different proteins. In sickle cell anemia the defect in gene product is the beta chain sub-unit of hemoglobin. If an individual's two hemoglobin genes code for normal beta chains, only normal or A hemoglobin will be present and the individual is a AA genotype.

A heterozygote with one gene for A hemoglobin and one gene for sickle or S hemoglobin has sickle cell trait (AS hemoglobin). This person does *not* have sickle cell anemia but is a carrier of the sickle cell gene.

Persons with sickle cell anemia have two abnormal hemoglobin

genes and most commonly are hemoglobin type SS; however, persons with types SC and S- β thalassemia also have symptoms of sickle cell anemia.⁴⁻⁶ S and C are alleles with different amino acid substitutions at the sixth position in the beta chain of hemoglobin. S beta chains have valine substituted for glutamic acid of A chains, while in hemoglobin C beta chains, the amino acid lysine has replaced the glutamic acid.⁷ Beta thalassemia functionally acts as an allele to S, C and A, in that it may involve a chromosomal deletion of portions of the beta chain gene or a regulator mutation so that little or no beta chain is produced from the chromosome carrying the thalassemia gene.⁸ In U.S. blacks approximately 8-10% have sickle cell trait (AS), 2-4% have AC hemoglobin and 1% have thalassemia trait.⁹

Counseling must make clear to individuals with hemoglobin variants that their hemoglobin type was determined prior to birth and will not change for any reason and that each individual will pass on one of the two hemoglobin genes to his or her children. Only if a child receives an abnormal gene from both parents will there be symptoms of sickle cell anemia.

The majority of couples seeking counseling will be at no risk of having children with sickle cell anemia. The most common mating which will be at risk involves couples where both partners have sickle cell trait. Using the 10% figure for simplicity, a mating between two blacks with sickle cell trait will occur approximately one out of every 100 times. The types

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Dr. Reed is director of genetic services, Indianapolis Comprehensive Sickle Cell Anemia Center.

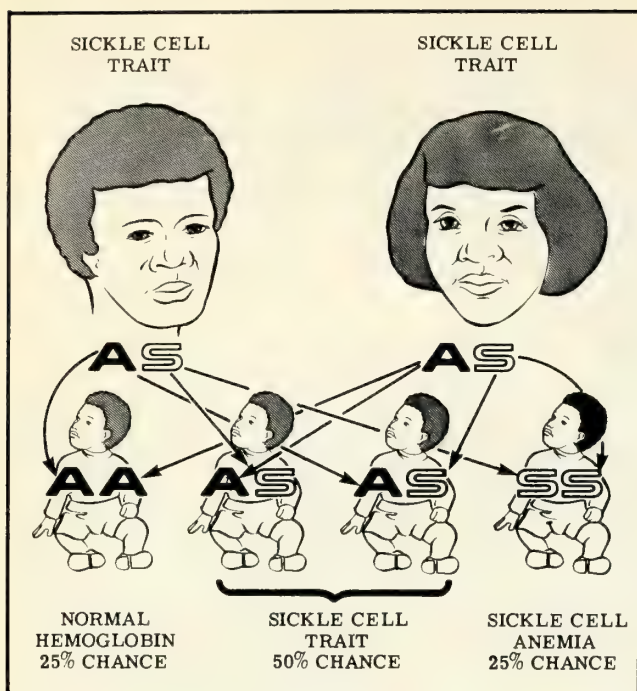


FIGURE 1
Possible types of children from couples where both parents have sickle cell trait (AS x AS).

of offspring a couple of this type can produce are shown in Figure 1. The couple will have a 25% chance of having a child with sickle cell anemia and a like chance of having a child with normal hemoglobin. Each child will have a 50% chance of having sickle cell trait.

Another way of determining the risk is shown in Table 1. The four boxes in the table represent possible combinations of genes, one of which is the homozygote for sickle cell hemoglobin; the risk of sickle cell anemia is, therefore, 25%. Either of these methods can be used to determine risks for any mating type, remembering that each parent will pass on only one of the two genes to each child. For example, it can be determined that the risk for SC disease in a child from a mating of AS and AC (1 in 250 black couples) is also 25% and the risk for sickle cell anemia is 50% when AS and SS (1 in 4,000 black couples) mate.

Alternatives and Course of Action

At present, for couples at risk for having children with sickle cell anemia, the only alternative, if they do not want any risk of having a child with sickle cell anemia, is to abstain from having offspring. Re-

cent studies indicate that the decision to have or not to have children in a variety of different genetic disorders correlates more with the perceived burden of having a defective child rather than the actual risk of having such a child.¹⁰ Stamatoyannopoulos¹¹ in Greece found that counseling of individuals with sickle cell trait had no great effect on their subsequent mating behavior.

Future research advancements in treatment¹² or prenatal diagnosis¹³ may allow for other solutions as are available for other genetic diseases. Regardless of the number of options available now or in the future, the genetic counselor presents the material factually, and, once the individual counselee or family makes a choice, the counselor fully supports that choice.

Adjustments

For persons with sickle cell anemia who want or need continued followup, the center provides varied services through the medical director, the social service director and the sickle cell anemia parent club. All patients are made aware of these vital services offered by the center in an effort to meet the entire needs of the family.

Some of the families may need to be reassured in dealing with the concept of carrying an abnormal hemoglobin gene. To bring the burden into better perspective, the counselor can remind them that everyone carries a few abnormal genes which, when combined with other like genes, would produce a disease. Persons with sickle cell trait happen to know what one of their abnormal genes is. Another way to help persons with sickle cell trait avoid self-stigmatization is to discuss the relationship of the protective effect that sickle cell trait affords against mortality from falciparum malaria.¹⁴ This, then, leads to explanation of why persons with black and some Mediterranean or Asian ancestry are at a higher risk to carry sickle cell genes and that under certain conditions (areas where malaria is endemic) it is beneficial to have sickle cell trait. In addition, it can be pointed out that other racial groups have different genetic diseases that are much rarer in black people, such as cystic fibrosis in caucasians and Tay-Sachs disease in Ashkenazi Jews.

Discussion

Counseling cannot stand alone as

TABLE 1
POSSIBLE TYPES OF CHILDREN FROM AS x AS

		Mother, AS (Sickle Cell Trait)	
		A	S
Father, AS (Sickle Cell Trait)	A	AA (normal)	AS (trait)
	S	AS (trait)	SS (anemia)

n isolated service and still be effective in accomplishing its aims. For reliable laboratory results, available medical support and other ancillary services are all necessary ingredients to be blended into an overall successful sickle cell center program. Each person receives counseling tailored to his own situation. At a minimum, it is hoped that all persons counseled will at least remember the difference between anemia and trait, be aware of their own order of risk and, most importantly, they or their physician will contact the center for help if problems arise related to sickle cell hemoglobin.

Table 2 displays a summary of the number and types of individuals,

TABLE 2
Individual, Parent or Guardian
Counseled in Families with Hemo-
globin Variants (1972-1975).

I.	Total	2,382
II.	Sex* - Male	985
	Female	1,397
III.	Age* - 0-12	1,022
	13-35	1,027
	>35	333
IV.	Hemoglobin type*	
	AA	1,069
	AS	890
	AC	297
	SS	25
	SC	31
	S-B thal	6
	Other	64

*Of person tested

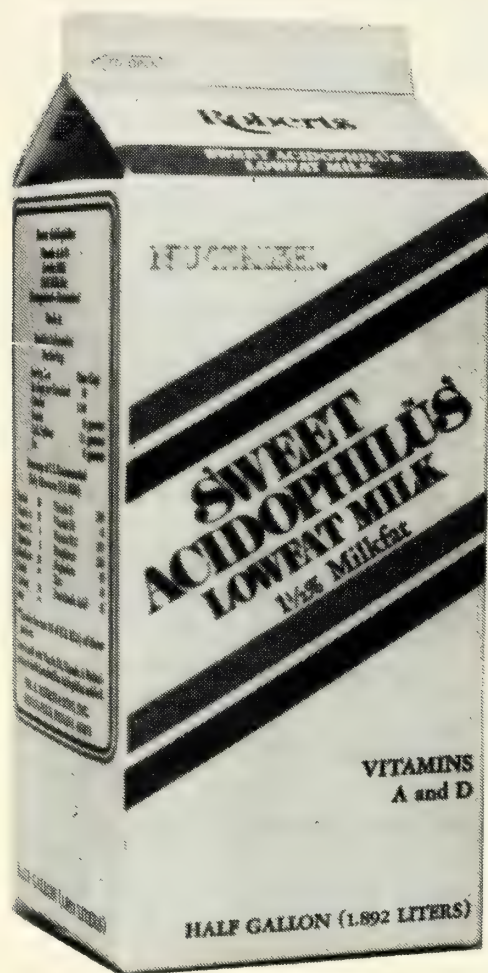
parents or guardians receiving genetic counseling since the center's inception. These figures reflect information on more than 500 families, one of which includes the first patient with sickle cell anemia reported from the state of Indiana in 1927,¹⁵ and who, it appears, may have had S- β thalassemia rather than the SS form of sickle cell anemia. As the referrals from physicians with both black and white families with hemoglobin variants is increasing, these numbers are steadily growing. ◀

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Hyperosmolar Hyperglycemic Nonketotic Coma

MAC C. ROLLER, M.D.
Franklin

THE causes of coma are diverse and the etiology can encompass one or several organ systems. Evaluating a patient with coma of undetermined etiology can be a rewarding diagnostic adventure or a frustrating clinical experience. Family physicians, by the very nature of first patient contact, should have a basic and sound step-by-step procedure for evaluation of such patients. If they later feel uncomfortable handling definitive extended therapy or, by the nature of the ultimate etiology, are not qualified to pursue continued care, they should at least be able to begin appropriate emergency evaluation and therapy and contact a consultant of the most significantly involved specialty.

The purpose of this paper is to review a problem which should be included in your thoughts on the differential diagnosis of coma. Hyperosmolar hyperglycemic nonketotic coma, as with other problems of ill-defined origin, may be more prevalent than its reported incidence, due to its relative lack of consideration as a possibility for diagnostic evaluation.

Hyperosmotic hyperglycemic nonketotic coma is often found in older individuals, recognized in conjunction with other disease entities, and is found with greater frequency as physician awareness of the possibility increases. This problem may most appropriately be called a hyperosmolar syndrome, since the clinical and laboratory manifestations have been reported to occur in conjunction with intracranial disease, renal dialysis,¹ steroid therapy² and burned patients with

or without known hyperglycemic tendencies.

Consideration of this entity should come when the physician encounters a comatose or nearly comatose individual having a very high blood glucose. Generally it will be 700 to 1,000 mg% or higher. This finding may be associated with a normal or elevated serum sodium and a blood urea nitrogen usually elevated and often out of proportion to the creatinine ratio. The osmolality of plasma can then be roughly estimated, if glucose, blood urea nitrogen and electrolytes are known, by use of the formula:

$$\text{Plasma osmolality} = 2(\text{Na}^+) + \frac{\text{Blood sugar (mg\%)} + \text{BUN (mg\%)}}{18 + 2.8}$$

Plasma osmolality will generally be over 325 mOsm/l³ (average normal 280-300 mOsm/l).

Indications are that mortality is high, 44-50%,^{4,5} and that the hyperglycemia of this condition is more sensitive to insulin than the hyperglycemia of ketoacidotic states. Whether generally true, or due to variability in evaluating small patient population, these assumptions are worthy of significant consideration in defining therapy.

Therapy itself, while not the primary intent of this review, is basically correction of hypovolemic shock when present and attainment of satisfactory urine output followed by replacement of water deficit and correction of hyperglycemia, recognizing that smaller than usual doses of insulin will generally greatly re-

duce the hyperglycemia in the non-acidotic hyperosmolar problems. Potassium loss during the stage of osmotic diuresis will need careful attention, especially if the patient has other medical problems or is on digitalis or diuretics. As the hyperosmolar problem responds, final balance can be achieved with oral fluids and usual insulin regulation.

In review, hyperosmolality can result in coma. This can occur with hyperglycemia per se⁴ and can be augmented by hypernatremia.¹ Hyperosmolar hyperglycemic nonketotic coma should be considered when dealing with an unconscious patient in which the etiology of the coma is in doubt. It has been recognized most often in the elderly, many times in conjunction with other medical problems, and carries a high mortality and a somewhat different therapeutic approach than diabetic ketoacidosis.

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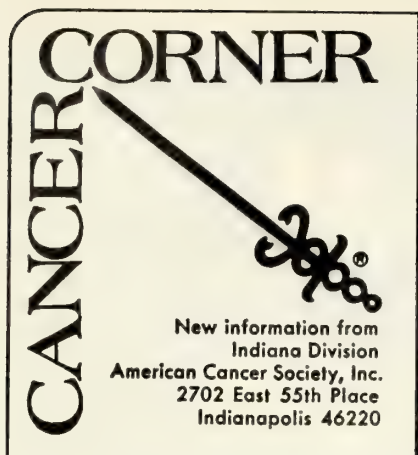
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WILLIAM M. DUGAN, JR., M.D.
President, Indiana Division
American Cancer Society, Inc.

20
150

H

20
100

E A R

20
70

I N G I S

A S P R E C I O U S

A S S I G H T H A V E

Y O U H A D Y O U R H E A R I N G

T E S T E D L A T E L Y A S I M P L Y

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I N V E S T M E N T O F A F E W M I N U T E S

Hearing losses are among the most consistently neglected health problems. Many

people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As

precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
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Beltone
WHEN A HEARING
AID WILL HELP



WHEN
BURNING PAIN
COMPLICATES
ACUTE
CYSTITIS*

TURN IT OFF WITH

AZO GANTANOL[®]

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

FOR THE PAIN

- Quickly relieves painful symptoms such as burning and pain associated with urgency and frequency.
- Recommended antibacterial therapy: up to 3 days with Azo Gantanol, then 11 days with Gantanol (sulfamethoxazole).

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura,

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

*nonobstructed; due to susceptible organisms

hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); G.I. reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. **Usual adult dosage:** 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.



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Each capsule contains 50 mg. of Dyrenium[®] (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium[®] (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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(Warning: May be habit-forming);
and acetaminophen 300 mg.



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Associate Editors: A. W. Cavins, M.D., R.R. 25, Box 172,
Terre Haute 47802; Lall G. Montgomery, M.D., R.R. 1,
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Business Manager: Donald F. Foy

3935 N. Meridian, Indianapolis, Ind. 46208

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Childhood Deaths by Auto

LETHAL childhood diseases are being prevented or cured at a progressive rate. All except one—the big one. The one that is not affected by ordinary prevention.

Traffic accidents are now the number one childhood killer. *The Journal of Insurance* rates automobile accidents as accounting for almost half of all deaths in children and—the percentage is still rising.

In the United States in 1974, 20,559 fatalities were recorded as due to motor vehicle accidents involving children from age 1 through 24. In Europe, child deaths from traffic accidents rose from 39% to 45% of all deaths in children in a period of 10 years. The record is not only bad, it is getting worse.

There is a time period in the first 25 years of life in which by far most of the fatalities occur. The automobile epidemic is most virulent between the ages of 6 and 14. This period is, as is emphasized by the Insurance Information Institute, the time after children leave the security of the home and before they acquire the know-how which is essential for survival.

Scandinavian authorities think that the basic reason so many traffic accidents involve children is that children simply are insufficiently developed physically and mentally to cope with traffic dangers.

Most adults think that children

can be trained to observe traffic safety rules. It appears that this is not so. Improvement of child safety in traffic will depend on teaching adult drivers that children cannot be taught the rules and cannot be depended upon for rational adult-type behavior around automobiles.

Children believe that cars can stop instantly. They have no idea of the distance required for stopping. They also think that if they raise their hand like a policeman does, the car will stop. Children on bicycles tend to devote their entire attention to operating the cycle. They have no spare time or attention for passing cars.

Other important differences between adult and child behavior in traffic is that the child has not learned to judge traffic by means of hearing, the child places too much faith in crosswalks, and, because of size, the child cannot see over hedges or over car hoods.

The best remedy for the situation is for a change in driver education to include greater emphasis on the behavior of children and the fact that when a child is hurt in traffic it is always the adult's fault, never the child's.

Most of the children in accidents are out alone. Many of those who are injured are known to be behaving in the correct manner at the time.

If the worsening accident toll is to be improved, it will depend on

adult education and more effective safe driving.

Guest Editorials

Words from the Speaker

HOPING not to appear pre-tentious, I am daring once again to prepare a series of articles for publication in our journal. Only this time, I promise to avoid becoming an active participant in internally controversial subjects.

I prepare these articles with the sole purpose in mind of illuminating matters that should be of avid interest to all the members of ISMA. This, I feel, is clearly a vital role to be served by the Speaker of the House. Perhaps through these articles, our membership may become better informed from a slightly different perspective than it is from staff and the higher echelons of organized medicine, thereby making the actions and results of our annual convention more productive.

I do not mean to convey the impression that staff and the leaders of organized medicine have not been supplying us with a plethora of communications on practically every subject of concern to the practice of medicine, for indeed they have! In fact, it is my suspicion that this is an important factor in our communications problem. Such a wealth of information oftentimes "overloads" the communications

circuits, and there is no possible way the busy county secretary can "triage" efficiently the reams of paper he receives from headquarters. A significant portion of vital information is certain to sift through his fingers into the "round-file" unread and hence uncommunicated.

As Speaker of the House, I look upon my office as one of "ombudsman" for the grass roots members via their elected delegates. I am deeply grateful to the members of the 1976 House of Delegates who elected me to this office. My gratitude extends assuredly to my predecessors, Drs. John Beeler and Bill Cast, who launched this neophyte office into a vital cog in the machinery of organized medicine in Indiana.

It is regrettable that Bill Cast found that his multiple commitments elsewhere in behalf of the practice of medicine compelled him to prematurely withdraw his speakership expertise from ISMA—at least for the time being.

I am most cognizant that I have some large shoes to fill. But the 1976 House eased this chore for me by electing a most capable vice-speaker in the person of Dr. Larry Allen of Anderson. I am confident that Larry and I together can do the job of presiding over the House of Delegates efficiently and fairly, expediting its most important transactions.

I do have some firm convictions as to the roles the speaker should and should not serve. It may seem strange that I feel that the speaker should not become a voting member of the Board of Trustees. I look upon the House of Delegates and the Board of Trustees as being a kind of two-house (bicameral) (medical) government—the Board being analogous to a Senate and the House of Delegates to a House of Representatives. While these two "houses" should work in concert with each other, their roles should be clearly defined and remain separate but equal.

Our legal counsel gives a some-

what divergent viewpoint than I have just given, but literal interpretation of legal opinion would emasculate the authority of the House and, hence, the membership. I'm certain this is not the intent of the law. The membership of no organization should be subservient to its elected leaders. Indeed, it is incumbent upon the leadership to to see that the consensus of the membership prevails and to be subservient to that consensus.

Making the speaker a voting member of the Board would most likely obscure the distinction between the House and the Board. Furthermore, the grass roots members should never again be left unrepresented by their own personal spokesman who carries some clout in determining policy and direction of organized medicine. I just happen to feel that becoming a voting member of the "hierarchy" would taint the office of speaker.

On the other hand, I will assure you that Larry Allen and I will be in attendance at most of the meetings of the Board and Commissions that frequently convene throughout the year at headquarters, considering myriads of important matters and making proposals for your consideration at the annual meeting. Our purpose in being present is advisory in nature—advising them of the will of the House and they advising us of issues they have studied in depth and deem important for House consideration. It is precisely this latter role that motivates my preparation of this series of articles. I hope you will find them informative and interesting, uncluttered with the stigma of "hierarchical propaganda."

LLOYD L. HILL, M.D.

Speaker of the House, ISMA
302 N. Duke St.
Peru 46970

A Proper Balance

"THE rules of the game are changing," a young doctor from southern Indiana said in Greensburg last week.

And with that statement, Dr.

Richard Graber of Orange County told the Health Professional Search Committee that most new physicians no longer regard the practice of medicine as an around-the-clock assignment which demands all of their time.

Instead, he said, doctors now value more free hours to pursue individual pleasures—at the same time remaining dedicated to a profession they enjoy.

Not too many years ago, such an observation would have been considered sheer heresy. Today, it may raise a few eyebrows—but we are inclined to side with Dr. Graber, at least to a point.

Whatever a person's job or profession, and whatever the need or demand for his or her services, no one should be expected to be at work or on call 100% of the time.

Free time, in fact, can make a person more efficient while at work—in that vacations, weekends and holidays provide periods to refresh our minds and juice up our batteries.

Doctors are no exception, and while some of us may cringe when we find that our family physician is away from the office when we need him most, we should remind ourselves that free time is not the exclusive right of the patient.

There is, however, a point of diminishing returns. And, in our opinion, a proper balance has been reached between free time and time on the job for most Americans.

To move toward even shorter work weeks (four days or less) and to adopt extended vacation periods will, we believe, seriously undermine the nation's work ethic and contribute to a severe decline in productivity.

We don't believe that is what Dr. Graber had in mind. There is, however, a continuing movement for what we regard as too much free time—and we can only hope that the majority of America's workers will be willing to say "whoa" before the imbalance begins to cripple an already sluggish economy.—**"Our Opinion" from *The Greensburg News*, Nov. 17, 1976.**

Editorial Notes . . .

"The Washington Post" made a survey of 2,500 persons in U.S. leadership positions. One question was "How much do you think a G.P. in a large city earns?" The answer was \$85,000. Second question: "How much should such a physician make? Answer—\$62,000, which amount is about \$3,500 more than the median for all doctors in U.S.

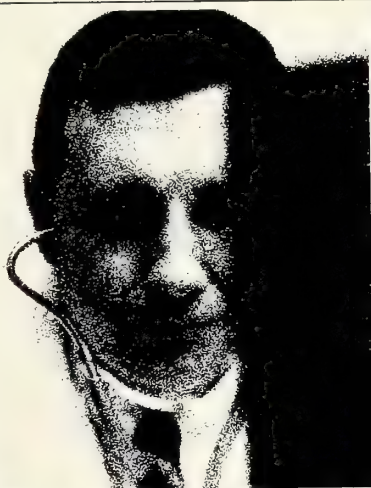
The Wellcome Research Laboratories of England have demonstrated a hormone which is generated in the intima of blood vessels which repels platelets and prevents clumping. The substance has

been named prostaglandin X or PGX. PGX can be formed by the vessels from another prostaglandin which is released by the platelets during the process of clumping. It is still early in this game but there is a possibility that new treatments and prevention may be developed on this principle for stroke and coronary thrombosis.

The National Academy of Science's report on surplus hospital beds recommends that the ratio of hospital beds to people be reduced by 10% by 1981 because the cost of maintaining a chronically empty bed is so high. Not so, says Michael Bromberg of the Federation of American Hospitals—effective hos-

pital management can reduce the cost to 10% of an occupied bed.

Study of hospital expenditures and revenues from 1967 to 1975 shows no significant difference in the financial picture between hospitals of 18 states, each state of which applied one of three cost control methods. One group, with six states, had some form of mandatory rate setting program. Another group of five states including Indiana had a voluntary rate setting program. The third group comprised seven states and had no rate setting regulations. The voluntary states showed a slightly better performance which was thought to be due to factors other than the rate control methods. ◀



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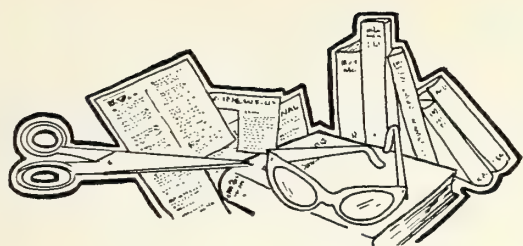
Membership Report

As of Dec. 31, 1976

As of Dec. 31, 1975

COUNTY	A	S	H	R	IR	M	ISMA	AMA	ISMA	AMA
Adams	11	1					12	11	12	11
Bartholomew-Brown	64	9	1				74	56	75	65
Benton	3	2	1				6	5	6	4
Boone	13	4			1		18	13	17	14
Carroll	7	1					8	8	8	8
Cass	28	2					30	24	30	26
Clark	54	1	1				56	37	55	37
Clay	10	2	1				13	13	13	12
Clinton	10	2					12	10	12	10
Daviess-Martin	15	1	1				17	11	18	14
Dearborn-Ohio	15	1					16	13	16	13
Decatur	9						9	9	11	10
DeKalb	13	4					17	15	18	15
Delaware-Blackford	111	13	1		11		136	96	137	102
Dubois	24	4	1		1		30	25	29	26
Elkhart	96	11	1	2			110	91	113	99
Fayette-Franklin	20		1				21	18	19	18
Floyd	45	6	1				52	45	53	43
FT. WAYNE-Allen	304	35	4		2		345	273	327	290
Fountain-Warren	9	2					11	9	11	9
Fulton	7						7	5	7	6
Gibson	8	4					12	12	13	13
Grant	68	8	1				77	69	81	80
Greene	11	5					16	10	15	11
Hamilton	12	1					13	8	14	11
Hancock	24						24	19	26	21
Harrison-Crawford	6	3					9	9	9	9
Hendricks	27	1					28	21	27	20
Henry	30	4	1				35	30	37	33
Howard	73	4	2	1			80	72	75	69
Huntington	16	6					22	17	22	17
INDIANAPOLIS-Marion	1,004	115	25	7	35	2	1,188	1,011	1,155	1,069
Jackson	15	3					18	16	19	16
Jasper	7						7	7	8	8
Jay	10	2	1				13	12	13	12
Jefferson-Switzerland	30	3					33	23	28	24
Jennings	4						4	4	7	7
Johnson	28	3	1		1		33	24	35	24
Knox	41	4	1				46	39	45	42
Kosciusko	17	2					19	10	20	14
La Grange	7	1					8	4	8	6
Lake	466	29	3		2		500	450	497	456
La Porte	88	9	1				98	81	94	79
Lawrence	36	3	1				40	28	35	23
Madison	92	14	2				108	67	101	64
Marshall	22						22	20	22	19
Miami	10	4					14	12	14	14
Montgomery	21	5		1			27	21	26	21
Morgan	15	1	1		4		21	17	20	16
Newton	5						5	3	5	4
Noble	12	3			1		16	15	16	15
Orange	7	2					9	5	7	6
Owen-Monroe	97	4	4				105	68	101	73
Parke-Vermillion	11	3					14	11	14	13
Perry	5	2					7	7	7	7
Pike	2						2	2	2	2
Porter	80	5					85	76	79	76
Posey	3	3					6	6	6	6
Pulaski	4	1					5	3	3	3
Putnam	13	2	1		1		17	16	18	18
Randolph	10	7	1				18	12	18	12
Ripley	6	1					7	5	8	7
Rush	9	2				1	12	9	12	12
St. Joseph	219	30	1	2			252	250	242	240
Scott	7	1					8	8	8	8

Continued



BOOK REVIEWS

PLAGUES AND PEOPLES

William H. McNeill, Anchor Press Doubleday, Garden City, N.Y., 1976; 369 pages; \$10.00.

Certain minds have a penchant for seeing ultimate truths or first causes and so are able to explain the erratic occurrences in this world which appear specious or capricious on superficial observation. The author of this popular history of the effects of, as he says, microparasitism and macroparasitism (i.e., war) on world history (and pre-history, for all of that) is promulgating the proposition that microbes are at least as important as mankind in the shapement of events. His case predicates on absolute determinist philosophy which might disturb the reader's preconceived notions of free will, but the author is startlingly convincing although his facts, necessarily, are conjectural.

The book covers man's sojourn on this planet from Chapter I "Man the Hunter" to Chapter VI "The Ecological Impact of Medical Science . . .", but concerns the whole historic canvas, such as the effects of civilized disease pools in the Middle East and the steppes of Eurasia, the macroparasitic Mongol Empire and, finally, the role of European and African microbes in the decimation of the aboriginal Amerindian population of the Western Hemisphere. Actually, he states in the Introduction that the idea came to him when researching his famous book "The Rise of the West," because Hernando Cortez subjected the Aztec Empire with only a handful of men. The power that the European had, albeit unbeknownst for the most part by him, was smallpox and other disease organisms which were usually endemic, also childhood fevers in Spain, Portugal, France, England and so on. This concept is the keystone of the author's treatise and he is very inventive in elaborating and even embroidering the central idea. Indeed, the one critique which cannot be sidestepped is the repetitiousness and prolonged worrying of the issue. Although McNeill's conception as he states it is measurably unique, perhaps he should defer a little more to Hans Zinsser (author of *Rats, Lice and History*) for the seminal status of that popular history.

Taken altogether, I believe every thoughtful physician would enjoy and benefit from a few hours with this author. It is a potent thesis that epidemic diseases may surpass power and money as a determinant in human history and now I believe it implicitly. Incidentally, the author writes elegant prose—that alone is rewarding for the reader.

RODNEY A. MANNION, M.D.
LaPorte

Membership Report

Continued

Shelby	18	2	1				21	16	21	17
Spencer	3	1					4	3	4	4
Starke	8	1					9	8	9	8
Steuben	12	1					13	11	12	12
Sullivan	9	3			2		14	12	16	14
Tippecanoe	147	18	3		1		169	144	172	145
Tipton	7	3	1				11	9	10	9
Vanderburgh	253	18	8	1	8		288	256	287	262
Vigo	100	21				1	122	93	121	105
Wabash	19	4					23	16	22	16
Warrick	6						6	4	5	4
Washington	8	1					9	7	8	7
Wayne-Union	68	10			1	2	81	67	80	74
Wells	43	3	2	1			49	48	51	50
White	7	1					8	8	8	8
Whitley	10	2					12	12	13	13
TOTAL	4,264	490	76	15	71	6	4,922	4,110	4,838	4,280

- A — Active—Full dues
- S — Senior—Exempt from dues
- H — Hardship/Disability—Exempt from dues
- R — Retired—One-half dues at state level
- IR — Intern-Resident—State and AMA dues
- M — Military—State and AMA dues

1976 Dues-paying members	4,356
Dues-exempt members	566
	4,922

I.S.M.A.	
1975	4,838
1976	4,922
	(+ 84)

SUMMARY	
A.M.A.	
1975	4,280
1976	4,110
	(- 170)

FUTURE MEETINGS, SEMINARS, COURSES

Seventh Family Medicine Review

The University of Kentucky Medical Center announces its Seventh Family Medicine Review, Session III, for Feb. 20-26 at Lexington. Fee is \$295. For further information, contact Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington 40506.

Mediclinics Offers Course in Florida

Mediclinics announces a spring seminar, to be held in the Galt Ocean Mile Hotel, Fort Lauderdale, Mar. 7-18. Sponsored by the Florida Academy of Family Practice and Broward Medical Center, the seminar has requested approval for 50 hours' credit by the American Academy of Family Practice. Registration fee is \$300. Information may be obtained by writing or calling Mediclinics, 832 Central Medical Building, St. Paul, Minn. 55104.

Small Child Symposium Scheduled

A Symposium on the Small Child will be held on Mar. 16 at the Kettering Center, 140 E. Monument St., Dayton, Ohio. It is sponsored by the Human Growth Foundation, Children's Medical Center of Dayton, and the Departments of Family Practice and Pediatrics, Wright State University. For further

information, write D. Methven Cathro, M.D., Children's Medical Center, 1735 Chapel St., Dayton 45404, or call 513-461-4790.

Institute Scheduled on Child With Learning Disabilities

A two-day postgraduate course "Institute on the Child with Learning Disabilities: Detecting, Evaluating and Helping" will be conducted at I.U. School of Medicine in Indianapolis on Mar. 25 and 26. For full information write to Nancy Roeske, M.D., 341 Riley Hospital, 1100 W. Michigan St., Indianapolis 46202.

Graduate Medical Assembly Sets Meeting

The New Orleans Graduate Medical Assembly will hold its 40th Annual Meeting from March 28 thru March 31, at the Fairmont Hotel in New Orleans. The program lists 17 distinguished speakers, together with a clinicopathologic conference and a trauma symposium. The registration fee is \$125, with students, residents, interns and fellows on a complimentary basis. Write to NOGMA, Room 1538, 1430 Tulane Ave., New Orleans 70112.

Neonatal Dilemmas Topic of Course

On April 12 and 13, Methodist Hospital, Indianapolis, will host its annual Newborn Symposium. Title of the symposium is "Major Dilemmas in Neonatal Pediatrics." Among topics to be discussed will be dilemmas of nursery staffing and environment, aspiration syndromes, oxygen monitoring and appropriate skin care of the young infant. For details, write Richard S. Baum, M.D., The Newborn Center, Methodist Hospital, 1604 N. Capitol Ave., Indianapolis 46202, or phone 317-924-8174.

Symposium on Polytomography Of Temporal Bone Announced

The 16th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, on Apr. 16 and 17. This continuing Medical Education activity is acceptable for 12 credit hours in Category 1 for the AMA Physician's Recognition Award (PRA).

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technic of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 20. Fee for the course is \$250.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis, 46219.



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NEWS NOTES

Section on Cutaneous Medicine Meets

Twenty-four dermatologic cases were presented and discussed at the annual meeting of the Section on Cutaneous Medicine Oct. 13 at the Regenstein Center, Indianapolis. Approximately 50 dermatologists and dermatology residents from Indiana and adjacent states attended the meeting, which was scheduled as a part of the ISMA Convention.

Dr. Emanuel Liss, South Bend, presided at the business meeting, at which **Dr. William Cron, Bloomington**, was elected secretary-treasurer.

Announces Lower Insurance Rates

The St. Paul Fire and Marine Insurance Company, which specializes in the claims-made malpractice policy, has reduced its rates for doctors in three states. The reductions average 20.5% and apply to those who are buying first-year coverage, but will affect all five years of the premium development cycle. St. Paul says that the actual effect of the revisions will vary because of the new ISO classification plan. The new plan, effective in 1976, provides uniform statistical information for insurance regulators and ratemakers. Seven basic rate categories are now applied to 99 different classes of doctors, instead of the previously used 26 classes.

Epilepsy Foundation Honors Dr. Dyken

The Epilepsy Foundation of America's Professional Advisory Board has elected **Dr. Mark L. Dyken, Indianapolis**, to a five-year term. Dr. Dyken is head of the Department of Neurology of the Indiana University School of Medicine, and he is the first Indiana physician to be so honored.

VA Announces New Outpatient Care Rules

New Medical benefits for veterans with a service-connected disability rated 50% or more now include VA outpatient care for any disability.

Following is a summary of the more important changes in outpatient care rules:

(1) Veterans with 50% or more service-connected disability now have the eligibility for outpatient care formerly reserved for those disabled by 80% or more.

(2) Post-hospital care is limited to 12 months except when a longer period is approved by the Administrator as being necessary to complete treatment.

(3) Ambulatory care provided "for the purpose of obviating the need for hospitalization" for a non-service-connected disability is limited to the extent that the services are available in VA facilities.

(4) Outpatient dental services for non-service-connected conditions are authorized only when necessary to complete work that was begun during a period of hospitalization.

(5) Payment of travel costs of veterans reporting to VA facilities for treatment of non-service-connected disabilities primarily is limited to those individuals unable to defray the costs of such transportation.

Dr. Beeler Addresses Annual Meeting of Indiana Philippine Medical Association

The Indiana Philippine Medical Association met recently to install new officers and conduct a scientific seminar. **Dr. John W. Beeler** was the guest speaker at the banquet. **Dr. Alejandro Pontaoe, Evansville**, is the new president. **Dr. Teodoro Guevara, Marion**, president-elect.

Physicians' Poems Published

Poems by two Indiana physicians, both Filipinos, are included in *New Voices in American Poetry 1976*, an anthology published recently.

Dr. Ernest C. Deza's contribution is titled "Beauty," and those by **Dr. J. C. Bacala, Scottsburg**, are titled "The Smallness of Us" and "Beyond Wind and Sea."

Cancer Society Elects Dugan President

Dr. William M. Dugan Jr., Indianapolis, was elected president of the Indiana Division of the American Cancer Society recently. **Dr. William Nowlin, Valparaiso**, is vice president.

ACP Elects Six New Fellows from Indiana

The American College of Physicians announces the election of 273 new Fellows at a recent meeting of the College's Board of Regents. Six Indiana physicians were honored, as follows: **Drs. Tushar K. Sinha, Akron; Jack T. Collins, Bluffton; Raymond L. Newnum, Evansville; Marge Chang, William H. Dick and Lawrence H. Einhorn, Indianapolis.**

Continued

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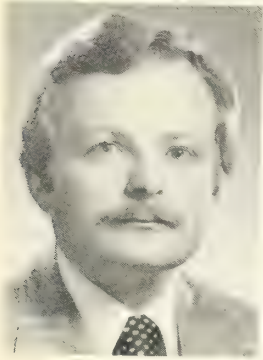
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Richard King Legislative Analyst



Richard R. King, II, Indianapolis attorney, became the legislative analyst for the Indiana State Medical Association on Dec. 1, 1976.

A graduate of the Indiana University School of Law, Indianapolis, in January 1975, he was admitted to the state and federal bar in May 1975. He received a Bachelor of Science degree in Political Science and Business Administration from Ball State University in 1971 and had recently been employed as a deputy prosecutor in the office of the Marion County prosecutor.

As legislative analyst, Mr. King will maintain a close working relationship with Indiana's legislators—locally and in Washington—to ensure that medicine's point of view is accurately depicted. He will work with the Commission on Legislation, which looks at all state and federal legislation and occasionally drafts a bill to deal with a pressing problem affecting the health care delivery system in Indiana.

Mr. King is the son of Mr. and Mrs. Richard King of Edinburg, and has served as a legal intern with the Johnson County prosecutor's office and with the office of the U. S. Attorney, Southern District of Indiana. He has also been employed as a research assistant with the Indiana Prosecuting Attorney Council and as survey coordinator for Region 5, Indiana Criminal Justice Commission.

Dr. John R. Poncher Honored

The Indiana Commission for the Handicapped named **Dr. John R. Poncher**, Valparaiso pediatrician, Indiana Physician of

the Year. The award, recognizing "exceptional contributions to handicapped persons" was presented at the banquet of the 15th annual Indiana Governor's Conference on the Handicapped.

Medicolegal Symposium Planned

The National Medicolegal Symposium for 1977, jointly sponsored by the American Bar Association and the American Medical Association, will meet Mar. 17 to 20 in San Francisco. For full particulars address Elizabeth Stein, Esq., American Bar Association, 1155 E. 60th St., Chicago 60637.

International Physicians Elect Dr. Grosz

Dr. Hanus J. Grosz, professor of psychiatry at the Indiana University School of Medicine, Indianapolis, was elected president of the American College of International Physicians at the annual meeting of the College in Chicago recently.

Dr. Grosz addressed the group on the topic "Benjamin Rush: American Patriot and International Physician."

Produce Films on Functional Bracing

Johnson & Johnson has supported the production of two medical films made by the orthopaedic department of University of Miami School of Medicine to explain functional bracing of forearm and Colles' fractures. This is a new method which, after the first two weeks of fixation, does not include splinting the elbow and wrist for forearm fractures and, after a few days, for Colles' fracture. Prints may be obtained on a free loan basis by writing Johnson & Johnson Patient Care Division, 501 George St., New Brunswick, N.J. 08903. The films are 16 mm, 16-minute, color, and are titled "Forearm Fractures: A Functional Method of Treatment" and "Colles' Fractures: Functional Bracing in Supination."

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There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

Limbs

I think "limb" is the best term for an arm-forearm-hand or a thigh-leg-foot combination. The term is short—it has only one syllable, and it is apt, for what is more appropriate than for limbs to come off a trunk, whether it is a tree or human body? A number of fine anatomists, including the late J. C. Boilleau Grant, have encouraged the use of the word "limb." And their efforts have not been in vain, for we see advertisements for artificial limbs, for example.

For some time the longer term

"extremity" has been in vogue. It's a longer word, four syllables, and violates one of the rules of anatomic nomenclature—that the term should be as short as practicable.

Then, too, as at least one man has observed, "What's so extreme about an extremity?" The most distal point may be taken as the most extreme point, and then we would be talking about finger tips or tips of toes when we talked about an extremity. Or "extreme" in some other sense could be implied by the word "extremity." But I don't think this word does the job as well as "limb" does; "limb" is

short and appropriate.

More recently, there has been an effort to call these parts of the body the "members."

I can't see what there is about an arm-forearm-hand combination that makes it any more a "member" of the body than the heart, thyroid gland or the penis. I think "member" misses the mark when it's compared with "limb." And "member" is one syllable longer.

I think we should use and encourage use of "limbs."

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From THE JOURNAL 50 Years Ago

Three outstanding factors have contributed in large part to the increased interest in the study of the heart which has been manifest during the past decade. First, the World War which afforded opportunity in all of the countries involved for the physical examination of some twenty-nine millions of young and middle-aged men. Second, the influenza pandemic of 1917-19, which wrought terrific cardiac havoc, and third, the development and perfection of such instruments of precision as the sphygmomanometer, sphygmograph, spirometer and, more particularly, the electrocardiograph.

These coincidental events have given such impetus to the study of the circulatory apparatus that cardiology has in a way developed into a new science, has given us an entirely new conception of cardiac disease. For many years we concerned ourselves almost entirely with a careful study of the function of the valves of the heart and were content when we had made a diagnosis of the competency or incompetency of this or that valve. While we still appreciate in full measure the importance of such anatomic investigation, we have come to recognize that the knowledge of paramount importance in the study of the heart is its evaluation as a power machine—of its ability to carry on—to meet the demands made upon it, often by an altered and pathological physiology . . . Edgar F. Kiser, M.D., Indianapolis "Heart Disease, Its Diagnosis and Treatment" JISMA, January 1927.

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From The Auxiliary



Happy New Year!

This month our report to you comes from Mrs. Lambro Dimitroff (Pat), editor of *The Hoosier Doctor's Wife*. Her job as editor of our state newspaper is:

- a. to convey national and state news out to the county.
- b. to convey news throughout the state.
- c. to generate readership interest.

Communication is the vital ingredient to the survival of any organization.

CHLOE GOLDSMITH
President, ISMA Auxiliary

"Organized medicine is in very grave danger for a number of reasons, not all unexpected. One of the primary reasons is that the physician envisions himself as having a closer relationship to his specialty society than to his county, state or national medical association. Furthermore, many medical societies do not utilize the talents available to them through their auxiliary members . . . but they need their auxiliaries and they need them badly."

These remarks were made by James H. Sammons, M.D., executive vice president, AMA, to 400 select auxiliaries at the Second Annual AMA Auxiliary Leadership Conference.

The ISMA Auxiliary wants to be of service to you, but, at the moment, is at a great disadvantage. While the Association has 4,800 members, the auxiliary has only 2,600; a large deficit. And the national figures are about the same, 200,000 AMA members and 90,000 auxiliaries. We need to increase our membership and your assistance can help accomplish this goal.

Briefly, the objectives of the Auxiliary are educational and charitable. But these broad generalizations are more meaningful when describing some auxiliary accomplishments.

In one year alone, auxiliaries across the country sponsored 71 nutrition, 105 child abuse, 155 drug abuse, 136 immunizations, 144 blood donor, 95 safety, 57 parenting and 138 screening programs, and these figures only scratch the surface in terms of people helped and hours of volunteer service given.

Through the LEGS (Legislation Effort Group System) program, there are 5,000 volunteers currently active in promoting activities to support health-related legislation. When the need arises, these LEGS chairmen contact people within their legislative districts to support sound legislation which affects the health and welfare of their communities, including such bills as National Health Insurance.

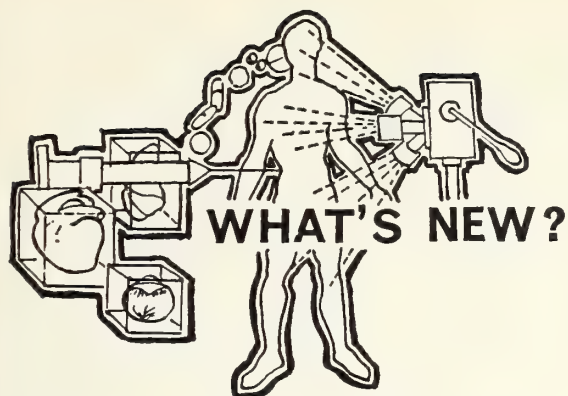
International Health reports from across the country recently show that 200 cartons of sample drugs and medical supplies, 28 cases of medicine, and 70.5 tons of miscellaneous supplies were sent to medical facilities around the world. In addition to these, countless shipments of supplies and hospital equipment, such as dialysis machines, are sent each year.

Since the inception of the AMA Education and Research Foundation in 1952, the auxiliary has contributed \$24,721,021 in unrestricted grants to medical schools, loans for medical students, interns and residents; funds for grants and scholarships for programs to support the quality and availability of medical care in underserved areas.

To assist county auxiliaries in their work, the AMA Auxiliary has a Project Bank which is an information clearinghouse for community projects. Begun in 1975, the bank now has a total of 300 different projects under 13 different categories. All projects have been tested as workable, listed alphabetically in the Project Bank Catalog and project copies are free just for the asking.

Sixteen years ago, Louis Orr, M.D., AMA President, went to Bangkok and saw their leprosy relief program. When he returned home he challenged the national auxiliary to do something. In 1961, the auxiliary responded by forming the International Health Agency. Dr. Orr challenged the auxiliary to help! Now, we are asking for yours.

PATRICIA DIMITROFF



Pfizer announces a new antihypertensive agent. MINIPRESS® (prazosin HCl) is prepared in capsules of 1 mg, 2 mg, and 5 mg. It is a chemically unique vasodilator, mild to moderate in activity, effective in all grades of hypertension. May be used alone or in combination with a diuretic and/or other antihypertensive agent.

* * *

Lederle has a new broad-spectrum semisynthetic penicillin, presently designated T-1220, which is effective against several types of difficult-to-control gram-negative bacteria. Detailed animal and human studies will continue. Preliminary work in Japan has shown *E. coli*, *Klebsiella pneumoniae* and *Pseudomonas aeruginosa* to be sensitive to the new antibiotic.

* * *

Baka Manufacturing has a new wrap-around support bandage. Made of patented panels of Helanca-lined elastic to prevent rolling and resist chafing. Dale Combo® Pile with Velcro closure provides adjustability. One size fits everyone. Made as rib belt, waist support, elbow, ankle and knee supports.

* * *

The National Retail Merchants Association, 100 W. 31st St., New York City 10001, has a "Checklist on the Hiring Interview" which can be obtained for \$2.00. Federal law makes it extremely inadvisable to ask certain questions of a prospective employee. It is an outstanding bargain even though it is a small 3-page folder. If one is an employer it is essential—if not, it is an education—absolutely priceless. Everyone should have a copy.

* * *

Lederle now makes STRESSTABS® with iron. Stress-tabs 600 now have added 27 mg of iron and also contain 0.4 mg of folic acid and an increase in vitamin B₆ to 25 mg. Recommended especially for women.

* * *

The Ames Company has a multi-media continuing education program on thyroid function. Titled "Focus: Your Thyroid Patient," the program explains the correlation between clinical findings and appropriate laboratory tests. Available without charge—half-hour film and Monograph/Workbook. Write Ames in Elkhart.

* * *

Cambridge University Press (American Branch) will release "Sensual Drugs" in January. It presents strong evidence that marijuana, as well as cocaine, heroin and all the hallucinogens, has devastating physical, mental and emotional effects. Hardcover \$15.95, paperback \$3.95.

* * *

Altura Health Publishers announce a new book with "new answers for hypoglycemics." The author is Richard Barmakian, a naturopathic doctor who is said to have cured the condition in himself with a regime which does not include high-protein-low-carbohydrate diet. 304 pages—\$8.95.

* * *

Dennison has a new plain paper copier. Named the BC-22, it has a first copy speed of only 5 seconds and produces 20 copies per minute, completely dry, on ordinary paper. It uses true bond paper and it can copy on one's own letterhead, on other preprinted forms, or on colored stock.

* * *

Academic Press has released a book which supports medical benefits of high dosage of vitamin C. "Vitamin C: Its Molecular Biology and Medical Potential" is the work of Dr. Sherry Lewin of the North East London Polytechnic. The book sells for \$17.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

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Deaths

John P. Baxter, M.D.

Dr. John Portland Baxter, chief of surgery at Winona Hospital, Indianapolis, died Oct. 20 at Lake Wawasee. He was 50.

A native of Jamaica, Dr. Baxter received his M.D. degree from the University of Ottawa (Canada) and interned at General Hospital, Ottawa. He did his residency training at Methodist Hospital, Indianapolis.

Dr. Baxter was on the medical staffs of St. Vincent, Methodist and Community hospitals, Indianapolis, and Hendricks County Hospital, Danville.

He was a diplomate of the American College of Surgeons and a member of the Marion County Medical Society and the American Medical Association.

Ivan A. Clark, M.D.

Dr. Ivan Andrew Clark, 71, Paoli physician and surgeon for 40 years, died at his home Oct. 3.

Dr. Clark founded and operated Clark Hospital in Paoli and was instrumental in the establishment of Orange County Hospital in 1959, of which he was chief of staff at the time of his death.

Following his graduation from the University of Louisville Medical School in 1935, Dr. Clark practiced medicine for a short time in the mining area of Kentucky, coming to Paoli in 1936.

Dr. Clark served as coroner of Orange County for 35 years. He also served more than one term as president of the Orange County Medical Society and served on the Legislation Commission in 1972. A member of the AMA, he attained senior membership status in 1976.

Carey B. Parker, M.D.

Dr. Carey Basil Parker, 81, retired Fort Wayne physician, died Oct. 21 in a nursing home at Fort Wayne.

A former deputy coroner and Allen County Coroner, Dr. Parker also served on the Fort Wayne Board of Health.

He was a 1921 graduate of the Ohio State University School of Medicine and interned at a Springfield, Ohio, hospital. He was in general practice and obstetrics.

A senior member of the Indiana State Medical Association, Dr. Parker became a member of the 50-Year Club in 1971. He was also a member of the Allen County Medical Society and the American Medical Association.

Robert O. Scott, M.D.

Dr. Robert Orsen Scott, Princes Lake, died Oct. 31 in Methodist Hospital, Indianapolis. He was 64.

Dr. Clark was a 1939 graduate of the Indiana University School of Medicine and interned at Methodist Hospital, Indianapolis.

A general practitioner at Charlottesville in Hancock County for 30 years, Dr. Scott had been plant physician for International Harvester Company in Indianapolis for eight years.

A past-president of the Hancock County Medical Society, Dr. Clark transferred his membership to the Marion County Medical Society in 1973. He was also a member of the American Medical Association.

Myron J. Van Dorn, M.D.

Dr. Myron James Van Dorn, Indianapolis, an anesthesiologist and practicing physician at Methodist Hospital and Morgan County Hospital, Martinsville, for 25 years, died Oct. 27 at home. He was 60.

Following his graduation from the Indiana University School of Medicine in 1944, Dr. Van Dorn interned in Eloise, Mich., at William J. Seymour General Hospital and served a residency at Methodist Hospital, Indianapolis, from 1949 to 1951.

During World War II Dr. Van Dorn was loaned by the Army Medical Corps to the Veterans Administration psychiatric service for two years and did special examinations for the Veterans Administration regional office from 1947 to 1949.

Dr. Van Dorn was a member of the Marion County Medical Society and the American Medical Association.

Jacob K. Berman, M.D.

Dr. Jacob Kohn Berman, Indianapolis surgeon, died Nov. 17 in Methodist Hospital. He was 80.

Dr. Berman was a professor of surgery at the Indiana University schools of medicine and dentistry for many years and was named professor emeritus of both schools in 1968. He served as chairman of the curriculum committee for the School of Medicine from 1932 to 1954.

Founder and former editor of the Indiana University Medical Center Quarterly Bulletin, Dr. Berman received his med-

ical degree from Jefferson Medical College, Philadelphia, in 1921. Since 1971 he had been visiting professor of surgery for Jefferson Medical College.

Former president of staff for St. Vincent and Wishard hospitals, Dr. Berman was chairman of research and education for Wishard from 1945 to 1963 and was chairman of the advisory council for St. Vincent from 1956 to 1962.

The author of numerous articles and scientific papers, Dr. Berman also wrote several books.

A founding member of the American Board of Surgery, Dr. Berman was also an active or founding member of many other medical and surgical groups. From 1959 to 1967 he lectured in Munich, Rome and Vienna. He was also the inventor of several surgical instruments.

A member of the Marion County Medical Society and the American Medical Association, Dr. Berman was a senior member of the ISMA and became a member of the 50-Year Club in 1971.

Ross E. Griffith, M.D.

Dr. Ross Earl Griffith, 67, retired Indianapolis obstetrician and gynecologist, died Nov. 13 in a nursing home. Dr. Griffith retired from his ob-gyn practice in 1968 and then worked in the anesthesia department at Methodist Hospital from 1968 until 1974. In 1967 he received a distinguished teacher award for "advancing the level of graduate medical education at Methodist Hospital."

A graduate of the Indiana University School of Medicine with the Class of 1936, Dr. Griffith interned at St. Vincent Hospital and served a residency at Methodist Hospital.

He was a member of the Marion County Medical Society and the American Medical Association.

Oran E. Kay, M.D.

Dr. Oran E. Kay, 82, Spencer, died in the Bloomington Hospital Nov. 5.

Although he retired from general practice in 1965, Dr. Kay served as school physician for the Spencer-Owen Community Schools until 1972 and continued to serve as Owen County Health Officer until Aug. 1, 1976, a position he had held for 28 years.

Dr. Kay graduated from the Indiana University School of Medicine in 1934 after a career as teacher and coach and

began his practice in Spencer in October 1934.

He was a member of the Owen-Monroe County Medical Society and served as a delegate in 1952. He was also a member of the American Medical Association.

Frank W. Oliphant, M.D.

Dr. Frank Wilson Oliphant, 63, former general practitioner at Mt. Vernon, died Nov. 7 at his home in Cadiz, Ky. He practiced in Mt. Vernon, from 1937 through 1965, when he retired.

During World War II Dr. Oliphant saw action with the 94th Evacuation Hospital at Salerno and Anzio in Europe.

A charter member of the Indiana Academy of General Practice, Dr. Oliphant was a member of the Posey County Medical Society and the American Medical Association. He served as his

county's delegate to the Indiana State Medical Association's annual meeting for many years.

William E. Sutton, M.D.

Dr. William Everett Sutton, Indianapolis urologist, died Nov. 1 in the Veterans Hospital at Marion. He was 67.

Dr. Sutton was in general practice in Edinburg from 1935 until he entered the Army in 1941. He held the rank of major when he left the Army in 1945. At that time he began a residency in urology at the Indiana University Medical Center, following which he was in private practice in Indianapolis until his retirement in 1967.

A graduate of the Indiana University Medical School in 1934, Dr. Sutton was a member of the Marion County Medical Society at the time of his death. He was also a member of the American Medical

Association and a number of urological societies. He was a diplomate of the American Board of Urology.

David D. Todd, M.D.

Dr. David Duke Todd, 94, retired Elkhart physician, died Nov. 5 in his apartment in La Jolla, California.

Dr. Todd received his M.D. degree from Rush Medical College in 1910 and was licensed to practice in Indiana in 1920. He retired from active practice in 1950, when he moved to California.

Among his services to the Indiana State Medical Association were as a member of the Pneumonia Committee in 1942 and the Cancer Committee in 1950. He was a member of the Elkhart County Medical Society and the American Medical Association. He was also a senior member of the Indiana State Medical Association.

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THE 1976 ROSTER OF MEMBERS

For convenience in handling and reasons of economy, this year's Roster was published as a Supplement to the June issue and was printed from information carried on our computerized Master File.

Additional copies of the Roster may be ordered at a cost of \$5.00. Copies of the June Yearbook are available at \$3.00. Please send check with order.

COMMERCIAL ANNOUNCEMENTS

PHYSICIAN'S ASSISTANT student is seeking a future position in a primary care or surgery practice in Indiana. Prefers to work with a group practice, but would consider a private practice. Available for preceptorship from June 1 to Aug. 31, 1977, and/or for employment after graduation Aug. 31, 1977. Contact: Steven M. Trimble, 410 Columbia Dr., Apt. 2, Columbia City, Ind. 46725.

WANTED: USED OFFICE EQUIPMENT for G.P. office. Interested in complete set-up. Reply to Box 410, THE JOURNAL.

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PHYSICIAN OPENING IN INDIANA REHABILITATION SERVICES INDIANA REHABILITATION SERVICES has openings for physicians in its various divisions. Interested persons should contact Dr. Walter E. Deacon, #1016 Illinois Building, 17 West Market Street, Indianapolis, Indiana, Telephone: 317-633-5961.

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DIRECTOR OF MEDICAL EDUCATION position available at Community Hospital of Indianapolis, Inc., Indianapolis, Ind. Responsible for senior elective program in cooperation with Indiana University Medical Center, Continuing Medical Education for the hospital's medical staff and residencies programs. Salary is open. There is opportunity for limited private practice. Interested individuals should write to Gerald Kurlander, M.D., chairman, Medical Education Search Committee, Community Hospital of Indianapolis, Inc., c/o Administration Office, 1500 N. Ritter Ave., Indianapolis 46219.

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FEBRUARY 1977

The JOURNAL

Vol. 70 • No. 2
Indianapolis

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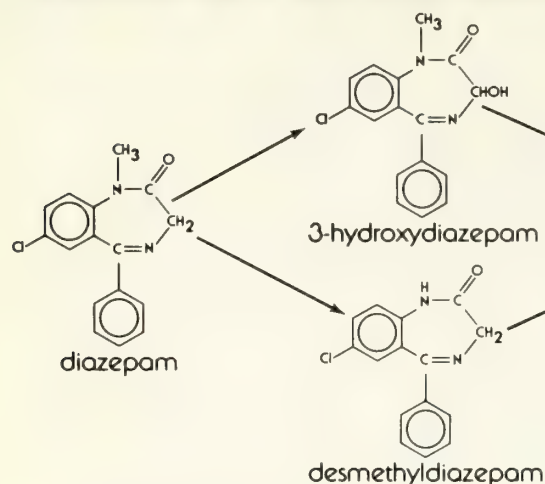


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Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

The pharmacokinetic profile of Valium is one of the characteristics that sets it apart from other benzodiazepines. Consider, in particular, the metabolic pathway of Valium. The three major metabolites of Valium exhibit significant pharmacologic activity—and so, of course, does the parent substance—diazepam itself. All combine to produce the characteristic clinical response seen with Valium. The response you have come to know, to want and to trust.

Pharmacokinetic studies also demonstrate that Valium has a pattern of absorption, distribution, metabolism and elimination that is reliable and consistent. And, although the pharmacokinetics of a drug cannot, at present, be specifically related to its clinical effects, it is clearly a factor that distinguishes one product from another by providing important insights into how each moves through the patient's body.

Valium® (diazepam) ^{IV}

2-mg, 5-mg, 10-mg scored tablets
**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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MEDICAL MUSEUM NOTES



A matriculation card for the course in Obstetrics and Diseases of Women and Children taught by Dr. John Evans of Rush Medical College was reproduced in the November 1976 issue of *The Journal*. Dr. Evans was such a remarkable man that it seems appropriate to tell more about his unusual career for the benefit of those readers not acquainted with it.

John Evans was born and reared near Waynesville, Ohio. He attended the Hicksite school in Richmond, Ind., and at the age of 23 (in 1837) commenced his formal training of medicine at the Cincinnati College headed at that time by Dr. Daniel Drake.

Dr. Evans graduated in 1838 and in December of that year married Hannah Canby. They moved to Attica, Ind., in 1839, where John opened his office for the practice of medicine. Early in his practice he became aware of the tremendous problems confronted by families having mental illness, blindness or deafness. The disturbing behavior of some types of mental illness resulted in the patients being chained in outbuildings and treated as though they were wild animals. In other instances, demented people of more manageable behavior would be put out to what was, in effect, slave labor to anyone providing food, clothing and shelter. Some patients were managed at home and others ran at large and were a public nuisance. Still others were locked up in jail or kept in poorhouses.

Dr. Evans considered the magnitude of this problem on a statewide basis and concluded that the state alone could muster the resources necessary to cope with it. He first formed a social club of interested citizens and then, in 1841, 1842 and 1843, petitioned the state legislature for action. Dr. Evans was assigned the task, following the appropriate legislative action, of selecting the site for the hospital, obtaining a plan and supervising construction.

He chose the Bolton Farm at Mt. Jackson, which was then three miles west of Indianapolis. Construction of the Indiana Hospital for the Insane commenced in 1846 and it was completed in 1848. Evans moved his family to Indianapolis in 1846 and practiced medicine here while supervising the building's construction. He became a member of the local medical society when it was organized in 1848.

Construction proceeded only during the warmer months. Dr. Evans joined the faculty of Rush Medical College in 1845 and taught there during the cold months.

With construction of the Indianapolis hospital completed, Evans moved to Chicago. Here he became involved with numerous activities other than teaching and the practice of medicine, although he re-

mained busy in these areas also. He was a founder of the Chicago Medical Society, editor and eventual owner of the *North-Western Medical and Surgical Journal*, and inventor of the "obstetrical extractor," a device for applying traction to the baby's head at birth with straps of silk. Dr. Evans considered this to be safer and cleaner than the conventional metal forceps.

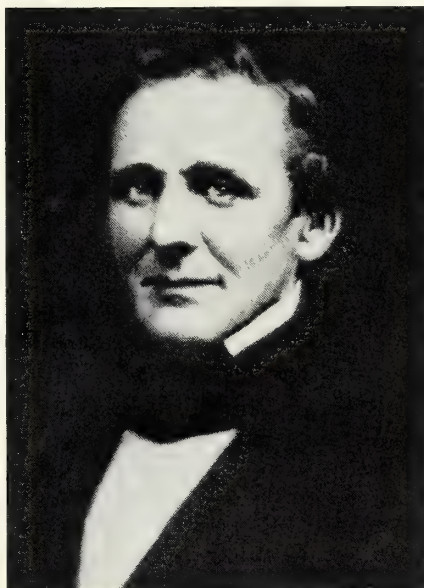
He built an office building in Chicago which was used by the U.S. Post Office Department and by the *Chicago Tribune*. He was a founder of Chicago's first hospital, a founder of the city of Evanston, and a principal founder of Northwestern University. He served on Chicago's City Council and was largely responsible for developing Chicago's lakeshore parks and public school system.

By 1855 Evans was more engrossed with his business ventures than he was with the practice of medicine and in 1857 he resigned his chair at Rush Medical College and gave up his practice completely. He was then 43.

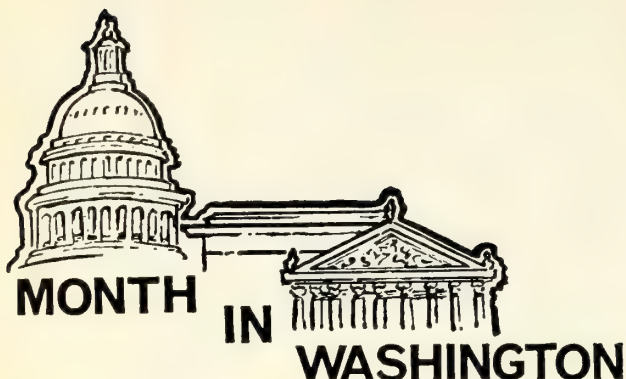
Dr. Evans became an early advocate and supporter of Abraham Lincoln for the presidency. Following Lincoln's election Dr. Evans was appointed territorial governor of Colorado. Later he became involved in building railroads across Colorado, and is responsible for Denver being the capital and principal city of Colorado. He also became involved in ranching, in building the University of Denver and other activities too numerous to mention here. He is listed on the Honor Roll of the Cowboy Hall of Fame at Oklahoma City. His image is preserved in stained glass in the capitol building at Denver, and Mt. Evans, southwest of Denver, is named in his honor.

Dr. John Evans died July 3, 1897. The Evans Building on the grounds of Central State Hospital was named for him.

CHARLES A. BONSETT, M.D.
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John Evans, M.D., 1814-1897



MONTH IN WASHINGTON

WASHINGTON LAWYER JOSEPH CALIFANO, JR., has been named Secretary of the Health, Education, and Welfare Department.

The 45-year-old native of Brooklyn is regarded as one of the Capitol's brightest men. He knows most of the workings of government inside out. He knows most of the congressmen of importance to HEW. And he knows most of the programs—many of them established during the "Great Society" days—that he will now administer.

The appointment of Califano to the politically sensitive position was the final cabinet selection by Carter, and was one of the best received. Liberals, including Ralph Nader, saw in Califano's "Great Society" background a promise of a bigger and better "Great Society"; conservatives found reassurance in Califano's reputation as a steady political veteran who is interested in cutting down on waste and inefficiency.

As President Johnson's chief domestic adviser in the mid-1960s, most of Califano's efforts on behalf of Johnson were in the welfare and education areas rather than health, where he doesn't have much of a track record.

He knows what he is up against at HEW. In a speech last summer, Califano said a new President will have a tough time coping with the entrenched bureaucracy. "The departments and agencies of the federal executive are a minefield of bureaucratic interests jealous of their jurisdictional turf," he said. The programs and their constituencies outside government "will be poised to oppose any change in the status quo."

Califano carved a reputation as an exceptionally able lawyer during the out-in-the-cold eight years of Republican

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

administration. It isn't unusual for top officials of outgoing administrations to land plushy jobs with Washington law firms, but Califano demonstrated that he was far more than a contact man. He was with the famous Arnold and Porter firm here, then he teamed with the equally prestigious Williams (Edward Bennett) and Connolly firm, where he served as counsel to the Democratic Party for two and a half years. After Harvard Law School he joined a New York law firm which once was headed by Thomas E. Dewey.

Lyndon Johnson asked him to come to the White House to serve as his domestic aide. There he was known as a driving, tough negotiator between labor and management over wage-price guidelines. He was interested in a systems analysis approach to budgeting federal agencies, which should mesh with Carter's enthusiasm for "zero-based" budgeting.

If Carter carries out his promise to give his department heads plenty of rein in policy matters, Califano might emerge as the chief policy architect in health affairs. Certainly Carter will rely heavily on him for advice. After years as a behind-the-scenes power, Califano will now be in the limelight.

A CONCERTED AND UNITED EFFORT by industry and labor to control medical costs is needed to avert a federal takeover of health which would "result in national expenditures of truly astronomical proportions," contends the President's Council on Wage and Price Stability.

Asserting that the day is coming fast when the people discover "how much they must increasingly sacrifice simply in order to maintain the status quo in health care services," the Council said the public's response would be to turn to the government for a solution.

"Absent any major changes in the structure of the medical care system between now and then, the federal government will step in, and when that happens, we are going to be faced with a permanent problem which will defy solution," said William Lilley, acting Council director, and his deputy, James Hedlund.

In a lengthy report on rising health care costs, the Council said "cost control incentives proposed by the private sector—that is, by industry and labor—promise to be more effective than those imposed by the multitude of government agencies which have attempted to tackle the problem . . . the private sector is motivated by an economic incentive which the government will simply never share."

The report said the government, in its Medicare and Medicaid programs, has a poor record of controlling costs. "The blizzard of rules and regulations which would accompany full federal financing and administration of the health industry would add to costs and reduce the limited incentives that now exist for efficiency and cost containment," the Council said.

The report pointed to company programs which encourage a second opinion before elective surgery. Some corporations have set up inhouse medical facilities because they have learned that this is a less expensive way of providing their

Continued on page 61



"GOOD HEAVENS, ORVILLE, LET HIM USE THE CAR KEYS IF HE WANTS!"

When **impotence** due to androgenic deficiency is driving them apart



Android-5 Buccal
Tabs
Android-10 Oral
Tabs
Android-25 Oral
Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome." *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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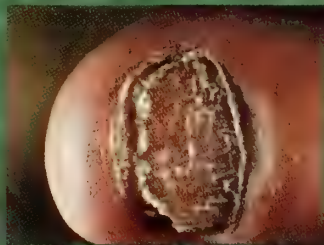
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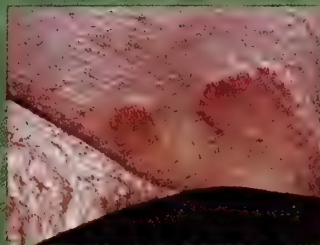
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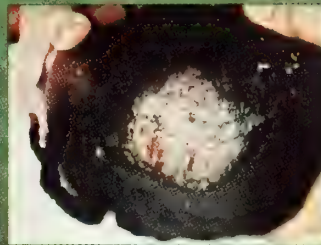
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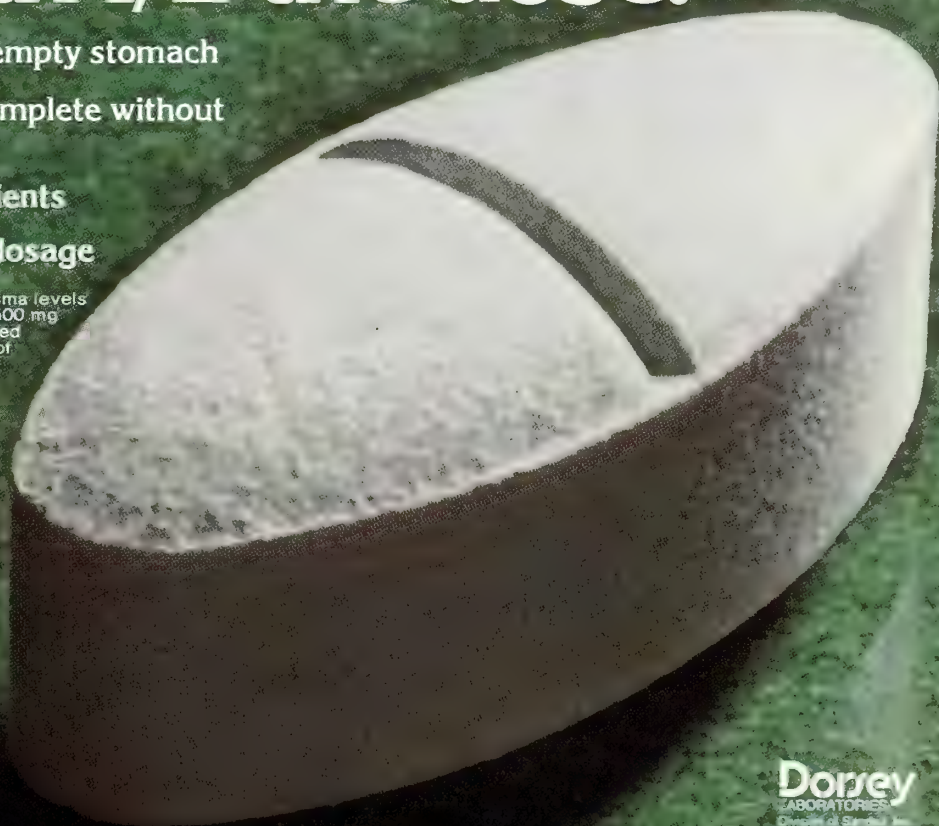
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- Reduced cost for patients
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[†]250 mg of Gris-PEG[®] provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



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DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsize griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy. Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitale
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleinii
Microsporum audouinii
Microsporum canis
Microsporum gypsum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatoma in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6

weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsize). USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

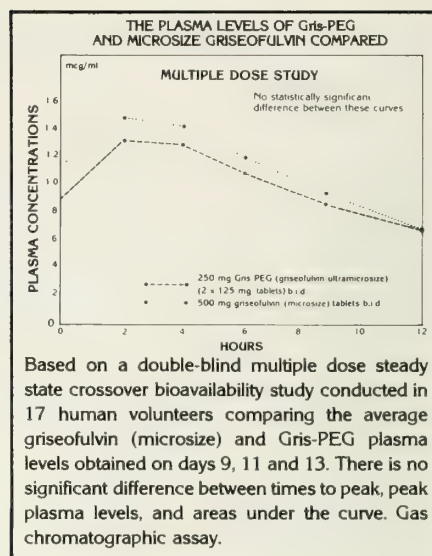
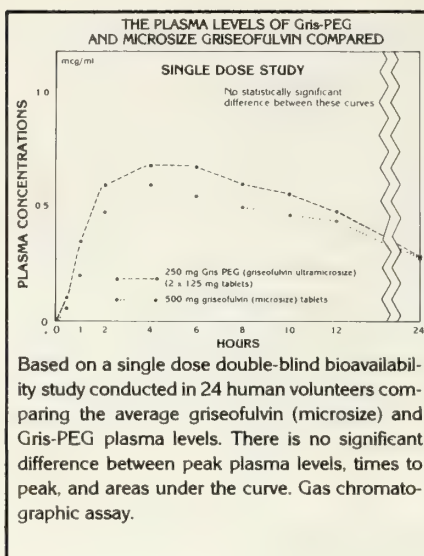
Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsize griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.



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Donnagel®-PG[®]

Donnagel with paregoric equivalent
For diarrhea

Each 30 ml. contains:

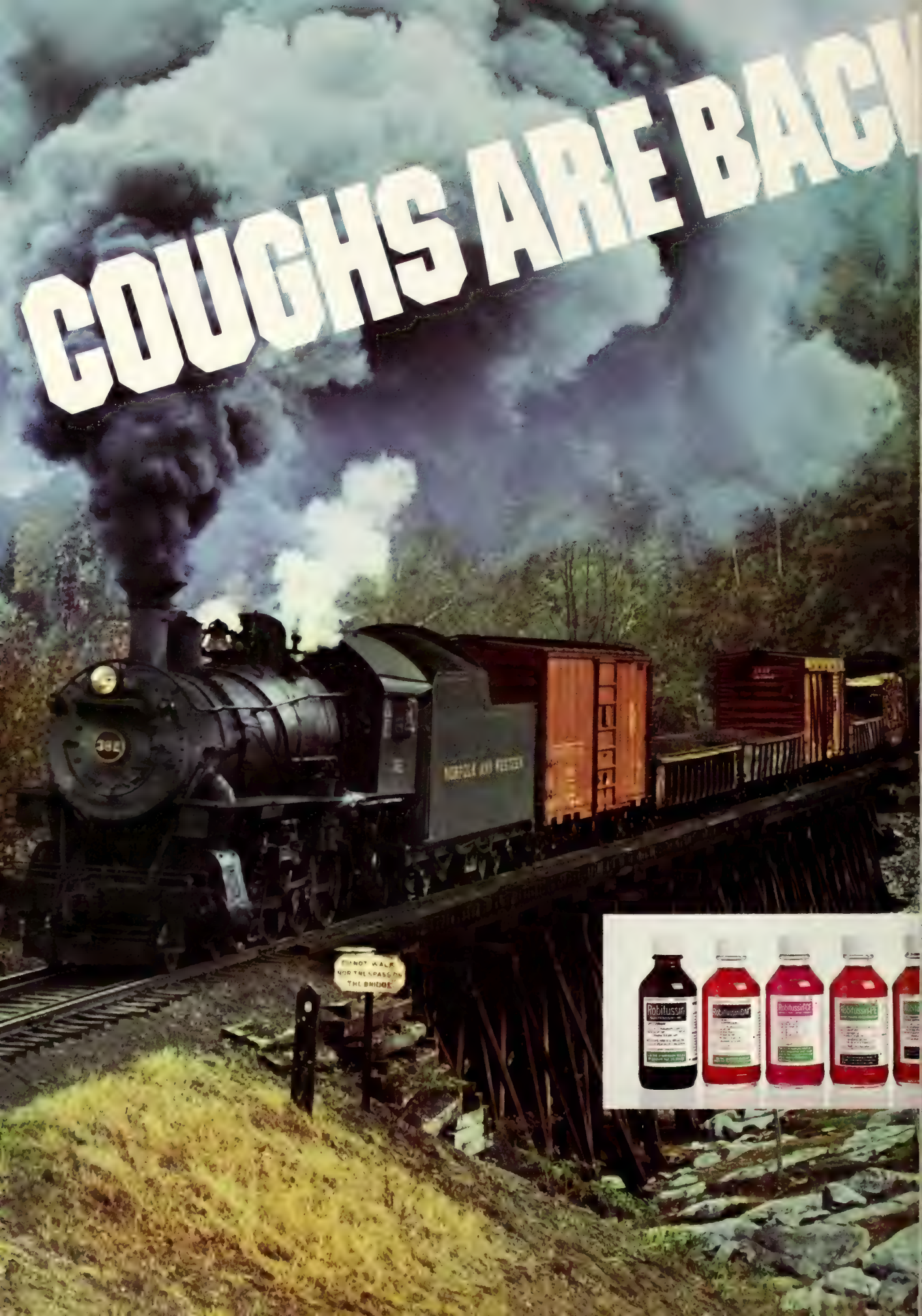
Kaolin	6.0 g.
Pectin	142.8 mg.
Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP	24.0 mg.
(equivalent to paregoric 6 ml.)	
(warning: may be habit forming)	
Sodium benzoate	60.0 mg.
(preservative)	
Alcohol, 5%	

A-H ROBINS

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NOR TRIPASS ON
THE BRIDGE



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clear the tract
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The 5 members of the Robitussin® family all contain the expectorant, guaifenesin, to help clear the lower respiratory tract. Guaifenesin works systemically to help stimulate the output of lower respiratory tract fluid. This enhanced flow of less viscid secretions promotes ciliary action and makes thick, inspissated mucus less viscid and easier to raise. As a result, dry, unproductive coughs become more productive and less frequent.

For productive and unproductive coughs

Robitussin®

Each 5 ml teaspoonful contains:
Guaifenesin, NF 100 mg
Alcohol, 3.5%

For severe coughs

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Each 5 ml teaspoonful contains:
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Codeine Phosphate, USP 10.0 mg
(warning: may be habit forming)
Alcohol, 3.5%

Non narcotic for 6-8-hour cough control

Robitussin-DM®

Each 5 ml teaspoonful contains:
Guaifenesin, NF 100 mg
Dextromethorphan
Hydrobromide, NF 15 mg
Alcohol, 1.4%

Decongests nasal passages and sinus
openings as it helps relieve coughs

Robitussin-PE®

Each 5 ml teaspoonful contains:
Guaifenesin, NF 100 mg
Pseudoephedrine
Hydrochloride, NF 30 mg
Alcohol, 1.4%

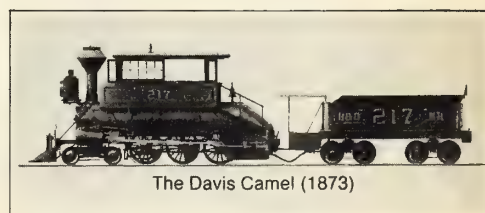
Decongestant action helps control cough and
clear stuffy noses and sinuses. Non narcotic.

Robitussin-CF®

Each 5 ml teaspoonful contains:
Guaifenesin, NF 50 mg
Phenylpropanolamine
Hydrochloride, NF 12.5 mg
Dextromethorphan
Hydrobromide, NF 10 mg
Alcohol, 1.4%

All Robitussin formulations available on your
Rx or Recommendation.

For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.



The Davis Camel (1873)

OUR PHOTO: Norfolk & Western Branch Train No. 202 west bound near Alvarado, Va. (Oct., 1956). This line reaches the highest point of any railroad East of the Rockies (elevation 3,577 ft.) with a minimum grade of 3%. It crosses 108 bridges, some 700 ft. long! Photo by O. Winston Link.

A-H-ROBINS

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Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to



neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Research Triangle Park
North Carolina 27709

employees with health care, says the Council. "Health maintenance units with salaried physicians have reduced costs," according to the report. "In other localities, corporations and unions have become involved on hospital boards and area-wide planning bodies to eliminate duplication of facilities and introduce other cost-saving efficiencies."

The Council said "the private sector must step up its efforts manyfold—it must apply the full measure of ingenuity and management skills which are so characteristic of the American system. In short, the private sector must start doing more, a lot more."

THE AMERICAN MEDICAL ASSOCIATION and state and local medical associations "have played a central role" in helping the Senate spotlight Medicaid fraud and abuse. The credit was given by Sen. Frank Moss (D-Utah), chairman of the Senate Aging Subcommittee that conducted the well-publicized investigations of Medicaid "Mills" earlier this year.

The Senator also said "the number of physicians who cheat" is very small.

In a letter to Richard E. Palmer, M.D., president of the AMA, Moss said "The Illinois Medical Society, the Chicago Medical Society and the Illinois Physicians' Union were directly responsible for my subcommittee's exposure to the problem of Medicaid 'Mills'."

The abuses highlighted in the subcommittee's report "exist for many reasons but AMA inaction isn't one of them," said Moss.

The Senator said the subcommittee's criticism "was not directed at contemporary medical practice."

"It was directed at a growing aberration in our urban ghettos called the Medicaid 'Mill.' The culprits we identified are greedy businessmen and real estate speculators. The same people we found pyramiding nursing home mortgages in New York. Now they have found a new gravy train. They hire foreign-trained physicians (we include podiatrists and chiropractors in the definition) and pressure them to see more and more patients in less and less time. The entrepreneurs keep from 50 to 70% of the money Medicaid pays to the foreign practitioner . . ."

Poor quality care results, Moss said. "It could hardly be otherwise, given the low Medicaid rates, the great delays in payments, the often and arbitrary denials of payment, as well as the all-encompassing pressure exerted on mill practitioners to grind patients through the mill. Little wonder reputable physicians avoid Medicaid practice. Even the best-intentioned physician would have difficulty functioning in this kind of environment."

In Medicaid, the "ripoffs" are taken by the clinic owners who, more often than not, are not physicians, said Moss.

The number of providers who abuse the Medicaid system may be four percent of total Medicaid participating physicians (including chiropractors and podiatrists) or less than two percent of all physicians in the United States, he said. This is hardly a blanket indictment.

Moss endorsed a statement by Dr. Palmer that other providers have a far worse track record as far as cheating the system. "I would include, for example, nursing homes, pharmacies that specialize in welfare clientele and clinical laboratories that do a high volume of Medicaid business."

The lawmaker wrote that "only with the assistance of the Medical profession can we seek to end the fraud and abuse which now haunts our government health care programs. We can bring providers who bill for services not rendered to the bar of justice, but a more complicated scheme inevitably involves questions of medical judgment which only physicians are capable of rendering."

A COMMISSION TO STUDY prescription drug usage and adverse reactions has been formed with the blessings of

Continued

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☐ Send latest information on Paget's Disease of Bone.
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Sen. Edward Kennedy (D-Mass.) and the funding of the Pharmaceutical Manufacturers Association (PMA).

PMA answered a challenge by Kennedy that the drug makers confront the problem by agreeing to fund an independent study commission for three years at \$250,000 annually.

"The problem of adverse drug reactions is definitely a problem," stressed PMA's Chairman Robert R. Clark.

Both Clark and Kennedy hope the commission will be able to design a system for post-marketing surveillance of drugs by the Food and Drug Administration so that both adverse reactions as well as new Drug indications become more quickly known. Such a system, termed "Phase IV" by Kennedy, could shorten the wait for pre-market approval of new drugs.

The 18 members of the Joint Commission on Prescription Drug Use were nominated by pharmaceutical and medical groups, including the AMA.

DRUG ABUSE REMAINS A "CHRONIC, persistent problem" in the United States with no simple solutions in sight, in the opinion of a joint annual report by federal agencies involved with drugs. The report proposed no basic shift in federal policy toward drug abuse, but suggested the possibility of lifting or easing criminal penalties for smoking marijuana.

The Strategy Council on Drug Abuse declared the government "ought to strongly discourage the use" of marijuana. "The question, however, is how do we most effectively accomplish this with the least cost to society."

President-Elect Jimmy Carter said during his campaign he favored decriminalization of possession of small amounts of the product, but he supported continued crackdowns on sale and distribution.

According to the report, marijuana carries a "relatively low social cost." Some 22 million Americans smoked marijuana last year, a "saturation" total that should prod the federal government into a decision on whether to continue to approach its use on a criminal basis.

The Council is composed of the Drug Enforcement Administration (DEA), the National Institute on Drug Abuse, the State Department and the White House.

CONGRESS IS SHOWING INCREASED INTEREST in the problem of maintaining confidentiality of medical records in the age of computers and vast federal medical programs. The House Commerce Subcommittee on Oversight and Investigations is considering hearings on the issue next year.

The most serious evidence of abuse so far came with state grand jury indictments in Denver of an investigative company—Factual Service Bureau, Inc.—on charges of selling confi-

dential records to large insurance firms. Factual was alleged to have had agents who were able to penetrate the records of the Federal Bureau of Investigation and the Internal Revenue Service, among others. Twenty defendants, including three insurance companies, have been indicted so far in the investigation launched by Colorado District Attorney Dale Tooley, who claims the evidence so far "is really the tip of a nationwide iceberg." Federal agencies are also pursuing the case.

The House Oversight Subcommittee, headed by Rep. John Moss (D-Calif.), is carrying on a running dispute with the Social Security Administration over the privacy of medical records in the Medicare program. "We believe very serious questions remain about privacy of records concerning individuals in custody of the Social Security Administration, especially in light of future plans," said Moss in a letter to SS Chief James Cardwell.

Social Security operates three data transmission systems which link private Medicare intermediaries with the SS Health Insurance Data Bank. The two less sophisticated computer systems, the Advanced Record System (ARS) used by private Medicare intermediaries in 16 locations, and the Programmable Magnetic Tape Terminals (PMTT) used by Blue Cross, Blue Shield and all but two other private intermediaries, use record retrieval systems "which cannot be abused by any employee of a private contractor either in an authorized or unauthorized manner," said Moss.

THE HEW DEPARTMENT HAS PUBLISHED final regulations under which Medicare providers may obtain judicial review of any final decision of the Provider Reimbursement Review Board, or of any reversal, affirmation or modification by the secretary.

The five-member Provider Reimbursement Review Board under Medicare hears Medicare appeals by institutional health care providers who disagree with the cost determinations made by health insurance organizations acting as fiscal intermediaries in Medicare hospital insurance.

Under the regulations, a Medicare provider may file for judicial review by a Federal Court after the final decision of the Provider Reimbursement Board or the HEW Secretary, but must do so within 60 days of the final decision.

HEW can review any decision of the Board but must do so within 60 days after the provider has been notified of the Board's decision.

THE MEDICAL SCREENING PROGRAM for children of poor parents has come under new attack. The Southern Regional Council, a private research group, said a study of 23 southern communities revealed "evidence of bureaucratic and political resistance to meeting the health needs of the program's relatively small target population—those under 21 years of age who are eligible for Medicaid."

Rep. John Moss (D-Calif.), Chairman of the House Commerce Subcommittee on Oversight and Investigations, has been a severe critic of HEW's operation of the early and periodic screening, diagnosis and treatment program. The Regional Council's report supported the Moss Subcommittee's earlier findings of lack of progress in the program.

The criticism is expected to be used to advance the cause of proposals in Congress to federalize Medicaid and to install new federal benefits for children and mothers.

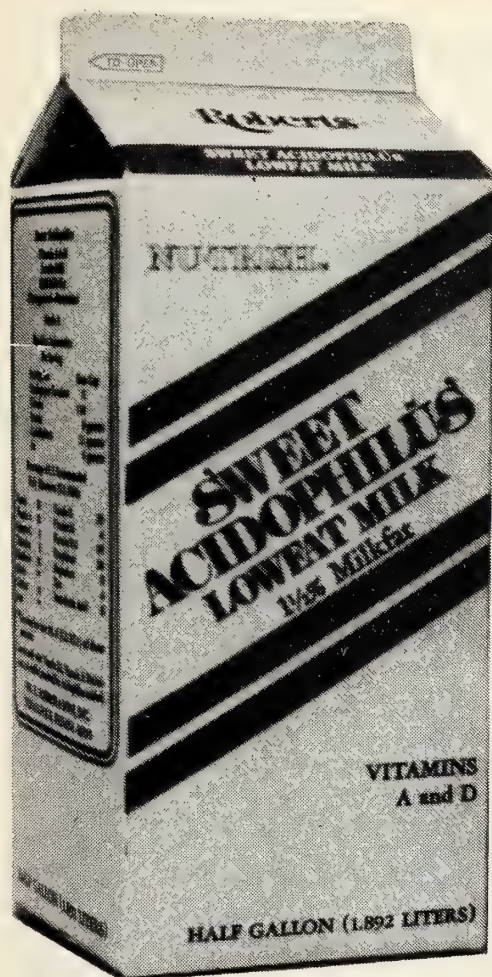
THE AMERICAN ASSOCIATION OF OPHTHALMOLOGY (AAO) has endorsed the national health insurance plan backed by the AMA in a position paper distributed to all members of Congress.

The Association said Ophthalmologists support the concept of legislation proposed by the AMA which "federalizes Medicaid, makes available variable tax allowances toward the purchase of health insurance, depending on the taxpayers' taxable income, and offers catastrophic insurance to all."



"Fortunately I was able to apply some first aid before you got here, Doctor."

FOR THE BODY NEEDING PROTECTION FROM ITS APPETITE!



Robert's Sweet Acidophilus low-fat milk is a drink for the whole family to enjoy daily — adults as well as children.

It is delicious, low-fat milk that is homogenized and pasteurized. But it has something special added, a natural culture which can aid the digestive systems of children and adults, which is why it is called "Sweet Acidophilus" milk. It is a milk with a sweet, fresh flavor to which has been added *Lactobacillus acidophilus* culture.

The raw acidophilus culture used in Robert's Sweet Acidophilus milk is an especially chosen strain. It can survive the acid conditions of the stomach and bile salts and does not affect the sweet, delicious taste of low-fat homogenized milk.

The special culture strain is harvested and concentrated using special procedures developed by scientists at North Carolina State University. It is the result of the painstaking research of these scientists that provides the consumer with the benefits of Robert's Sweet Acidophilus low-fat milk.

HERE'S WHY ROBERT'S SWEET ACIDOPHILUS LOWFAT MILK HELPS THOSE WHO SUFFER FROM DIGESTIVE DISTURBANCES!

When Robert's Sweet Acidophilus milk is consumed, the tiny acidophilus cells find their way to the intestines. In the intestines, there are millions of bacteria working beneficially helping to digest the food.

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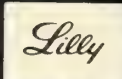


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Coronary revascularization has been utilized in selected cases of acute myocardial infarction. Three cases are described in which acute myocardial infarction occurred while the patients were in the hospital and in which emergency surgery was performed.

Myocardial Revascularization in Acute Myocardial Infarction

JOHN H. ISCH, M.D.
WALTER W. JOLLY, M.D.
HARRIS B SHUMACKER, JR., M.D.
Indianapolis

DIRECT myocardial revascularization has dramatically altered the general management of arteriosclerotic coronary artery disease. Obstructive focal lesions in the proximal segments of the coronary vessels result in diminished coronary blood flow and myocardial ischemia. Revascularization of the distal coronary arterial tree with bypass grafting increases coronary flow and thereby diminishes myocardial ischemia.

Chronic stable angina that is refractory to medical management and accelerated angina are clinical syndromes that benefit greatly from myocardial revascularization.^{1,2,25,35} Anatomic coronary lesions which constitute an immediate threat to life and coronary artery stenosis with concomitant valvular lesions or ventricular aneurysms are also accepted indications for bypass grafting. Recently, however, emergent aortocoronary bypass grafting has also been carried out in selected cases of acute myocardial infarction.^{5,26,28,30} This report describes

three such cases and discusses the general implications.

Case Summaries

Patient No. 1 was admitted to St. Vincent Hospital on Dec. 31. She had experienced typical angina pectoris for the past four years which had accelerated in frequency, duration and severity one month prior to her admission. Two weeks prior to admission she was admitted to an outlying hospital with severe chest pain that resolved with analgesics. She had no electrocardiographic or enzymatic evidence of myocardial infarction at that time.

During her initial hospital stay she continued to have anginal episodes that required four to six nitroglycerin tablets a day for relief. The morning her cardiac catheterization had been electively scheduled she developed severe, crushing anterior chest pain and hypotension. Her electrocardiogram at that time suggested an acute antero-lateral myocardial infarction.

She was treated aggressively with

oxygen and vasopressors and her cardiodynamic function very quickly stabilized. Her chest pain, however, continued and she was taken directly to the cardiac catheterization laboratory, where a left heart catheterization with selective coronary angiography was performed. This study documented a normal left ventricular end-diastolic pressure and a normal sized chamber but a definite hypokinetic antero-apical left ventricular segment. There was a high grade significant focal obstructive lesion in her proximal left anterior descending coronary artery. (Fig. 1) The right main coronary artery was totally occluded just distal to its origin with collateral vessels to the distal right system from the left coronary tree. The circumflex vessel demonstrated diffuse but nonobstructive disease.

The patient was taken from the catheterization laboratory directly to the operating room, where an uneventful double aortocoronary bypass graft to the mid-left anterior descending and right posterior de-

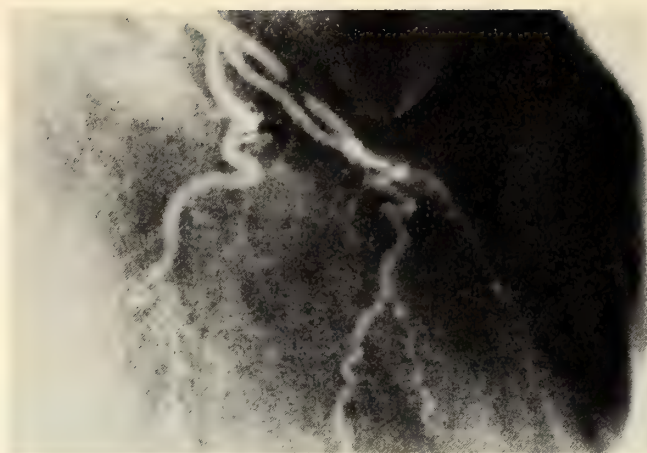


FIGURE 1.
RIGHT anterior oblique projection demonstrating obstruction in left anterior descending coronary artery.

scending coronary artery was performed. The patient required vasopressors initially to come off cardiopulmonary bypass but then stabilized and needed no further cardiodynamic support. Postoperatively, her acute electrocardiographic changes resolved and she had no further enzymatic or electrocardiographic evidence of muscle damage. Her hospital course was uneventful with the exception of the development of atrial fibrillation on the eighth postoperative day. She was converted to normal sinus rhythm with appropriate medical management and was discharged on the 12th postoperative day.

Ten months following her revascularization she remains angina free and without symptoms of congestive failure.

Patient No. 2 was a 50-year-old woman who was in generally good health until five weeks prior to her admission, when she developed sudden angina and shortness of breath. Her chest pain was precipitated by exertion, emotion and eating heavy meals. She was treated with coronary vasodilators and Inderal but continued to have effort-related chest pain.

Her admission electrocardiogram demonstrated normal sinus rhythm with ST segment depression in the anterolateral leads and no evidence of an old myocardial infarction.

Two days following her admission she was taken to the cardiac

catheterization laboratory, where left heart catheterization and coronary angiograms were performed. She had an elevated left ventricular end-diastolic pressure of 25 mm Hg with a markedly hypokinetic anterior and inferior left ventricular wall. She had no valvular lesions or intra or extra cardiac shunts. Coronary cineangiograms demonstrated a high grade left coronary ostial stenosis with normal distal left anterior descending and circumflex vessels. (Fig. 2) The right coronary artery was diminutive without obstructive disease. There was retrograde filling of the distal left anterior descending coronary via right collaterals. The patient did not become hypotensive or arrhythmic during the left coronary cineangiograms.

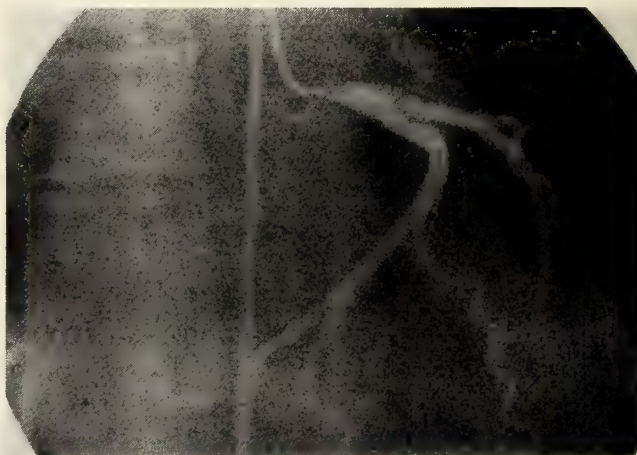


FIGURE 2.
RIGHT anterior oblique projection demonstrating tight left coronary ostial lesion.

Approximately 10 minutes following the cardiac catheterization the patient suddenly became bradycardiac and hypotensive and with markedly ischemic ST-T wave changes. She deteriorated into ventricular fibrillation and then became totally unresponsive. Vigorous resuscitative efforts were begun immediately and included cardiac massage, vasopressor support, intubation and ventilation. The patient responded to these measures and within 30 minutes stabilized cardiodynamically without further aid of vasopressor support. She was alert and oriented but experienced continuing severe anterior chest pain. The ischemic electrocardiographic pattern continued.

The patient was taken directly to the operating room, where emergency surgical revascularization was performed. Saphenous vein bypass grafts were placed to the proximal left anterior descending and left main circumflex coronary arteries. The patient came off cardiopulmonary bypass smoothly with minimal vasopressor support. Her postoperative course was quite benign. Her ischemic electrocardiographic changes resolved and she had no further evidence of an acute infarction. Her postoperative course was uncomplicated and she was discharged 11 days following her surgery. Six months postoperative she remains angina free and without symptoms of congestive failure.

Case No. 3 is a 60-year-old man admitted urgently in November with a two-hour history of crushing anterior chest pain. He had had an inferior myocardial infarction the previous January with an uneventful convalescence. He was angina free until one week prior to admission, when he had an episode of classic exertionally related angina. He had no further chest discomfort until the onset of his pain resulting in his admission.

On admission to the coronary care unit he was hemodynamically stable with a blood pressure of 135/70 and a sinus rhythm at 80 per minute. Electrocardiographically, he had evidence of an acute evolving anterior lateral myocardial infarction, with elevated ST segments in V2 through V5 as well as loss of R wave amplitude in these leads. Cardiac enzymes on admission were at upper limits of normal.

The patient was taken promptly to the cardiac catheterization laboratory where an uneventful procedure was performed. His coronary cineangiograms demonstrated a totally occluded distal right main coronary artery with retrograde filling of his posterior descending vessels from the left system. He had a 95% obstructive lesion in his proximal left anterior descending and an 80% obstructive lesion in his main circumflex vessel. His ventricular contractility was mildly impaired with no localized dyskinesia. His left ventricular end-diastolic pressure was elevated at 25-30 mm Hg at rest.

The patient was taken directly from the cardiac catheterization laboratory to the operating room, where a triple aortocoronary bypass graft was performed. Saphenous vein grafts were inserted into the left anterior descending, obtuse marginal and right posterior descending coronary arteries. The operative procedure went smoothly and the patient came off bypass with no difficulty.

The patient's early postoperative course was uneventful. Approximately 72 hours following surgery he developed sudden transient hy-

potension with his blood pressure dropping from 140/90 to 90/70. He had no evidence of acute blood loss, pericardial tamponade or cardiac rhythm changes. His hypotension resolved within a period of 12 hours with appropriate volume replacement and transient vasopressor support. He had no acute electrocardiographic changes. He had no further significant cardiodynamic problems during his convalescence.

Postoperatively, the ischemic ST segment changes did not resolve; however, no pathologic Q waves evolved. With these electrocardiographic findings, as well as his hypotensive episode, it is assumed that the patient did sustain some degree of anterolateral myocardial damage. However, his course would suggest that the size of his infarct was minimized by the revascularization. The patient was discharged on the 15th postoperative day free of angina or congestive failure symptoms and has remained well until this time.

Discussion

Data from the Framingham study²⁹ indicate that the most common presentation of ischemic heart disease is myocardial infarction, half of the patients having infarction as the first event.¹ While only 4% die, this group of patients with acute myocardial infarction comprises the largest category of in-hospital deaths in the United States.³ Ninety percent of these deaths result from pump failure or arrhythmias.⁹

Clinical experience with cardiac surgery during the acute phase of myocardial infarction has dealt largely with this latter group of high-risk patients. Procedures which have been performed include acute infarctectomy,^{7,13} closure of a ruptured ventricular septum,^{11,12} mitral valve replacement for acute papillary muscle dysfunction or rupture,^{6,12} resection of ventricular aneurysm,^{8,14,18} and direct coronary revascularization.^{15,24}

Eighty to ninety percent of patients die who develop low cardiac output states refractory to aggressive medical management following

acute myocardial infarction. The majority of these deaths result from primary myocardial ("muscle") failure or mechanical hemodynamic lesions such as acute ventricular aneurysm, ventricular septal defect or mitral valve dysfunction. Emergent surgical correction of the mechanical defect has markedly improved the survival in this latter group. Mechanical circulatory assist devices, particularly intra-aortic balloon counter-pulsation, when combined with emergency angiography and acute revascularization, have been used with modest success in the group with primary pump failure.^{23,27}

None of the patients presented here had refractory pump failure or arrhythmic problems. Two had accelerated angina. One patient developed clinical and electrocardiographic signs of acute myocardial infarction while awaiting cardiac catheterization. Another developed these same findings immediately following the study. Both these patients became markedly hypotensive but responded well to vigorous resuscitative efforts with stabilization of blood pressure and rhythm. The third patient had, on admission to the coronary care unit, electrocardiographic evidence of an acute anterior lateral infarction and had a two hour history of chest pain preceding admission. This patient was cardiodynamically stable before, during and after catheterization.

It is now well known that the extent of tissue necrosis consequent to myocardial infarction is not irrevocably determined at the time of acute coronary occlusion. Chatterjee and his colleagues⁴ have nicely shown that the depression of left ventricular function resulting from acute myocardial ischemia can be reversed with immediate myocardial revascularization. Maroko and Braunwald²⁰ have recently summarized diverse manipulations that in animals have been shown to reduce the extent of myocardial damage following acute infarction. These include intra-aortic balloon counter-pulsation, inhalation of an oxygen enriched atmosphere, in-

hibition of complement components and various drug regimens.

Acute revascularization of the described patients was performed in an attempt to reduce the extent of myocardial damage following acute coronary occlusion. By immediately restoring blood flow to the area of impending myocardial necrosis and ischemia it was hoped to minimize the amount of myocardial cell death and eliminate marginally perfused ischemic myocardium. (Fig. 3) Two of our patients recovered uneventfully without clinical or electrocardiographic evidence of ischemia or infarction. The remaining patient had persistent ischemic electrocardiographic changes post-operatively, but except for one transient bout of hypotension, had an uneventful convalescence. All patients have remained free of angina and failure symptoms post-operatively.

It is not being proposed that all patients sustaining acute myocardial infarction undergo emergency aortocoronary revascularization. Indeed, this is logistically impossible. Elapsed time between the onset of ischemia and completion of revascularization is critical if myocardial damage is to be minimized. Although this clinical time period is probably variable and unpredictable with each patient, it has been suggested that four to eight hours is the maximum interval during which revascularization must be performed. Obviously, then, a patient managed in this way must either be in or have immediate access to a facility with diagnostic and opera-

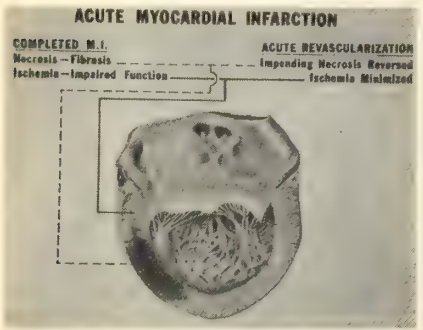


FIGURE 3.
POTENTIAL benefit of revascularization during acute myocardial infarction.

TABLE I
Operative Mortality in Myocardial Revascularization of Acute Myocardial Infarction
(Without Cardiogenic Shock or Intractable Arrhythmias)

Author	No. of Patients	Duration- (MI—O.R.)	No. Surviving Patients	Mortality
Keon, et al. (16)	7	3 hr. - 30 d.	7	0
Cheanvechai, et al. (5)	37	3 hr. - 14 d.	35	
Reul, et al. (26)	14	2 hr. - 2 d.	10	
Scanlon, et al. (28)	8	2 hr. - 2 d.	7	
Smullens, et al. (30)	14	Unknown	12	
Bolooki, et al. (2)	5	Unknown	5	
Isch, et al.	3	1 - 4 hrs.	3	
	88		79	10.7%

tive facilities required for this type treatment.

The group of patients with unstable angina is certainly at high risk for the development of acute myocardial infarction. The frequency with which this occurs remains indefinite but available data suggest that 15-40% of patients with crescendo angina will infarct within three to twelve months.^{10,17,19,34,36} Conversely, retrospective studies have shown that from 30-70% of patients with acute myocardial infarction manifest premonitory symptoms prior to their acute attack.^{22,31,32} These patterns of symptomatology include recent onset of angina, increased duration, frequency or severity of previously stable angina, and return of angina following a pain-free period after a myocardial infarction. In this group of patients, variously referred to as having "accelerating, unstable, pre-infarction angina, status angionosis, or intermediate coronary syndrome," urgent diagnostic study is indicated. If angiographic evidence of high grade obstruction is documented in the left main coronary artery or its two major branches, these patients are believed at risk and, therefore, candidates for prompt revascularization. The operative mortality and result of operative treatment in this group of patients are not significantly different than in the group with chronic stable angina. In a combined series of 420 patients the operative mortality was 4.3%, while symptomatic relief compared quite favorably with those treated for stable angina.³³

If acute myocardial infarction occurs in the hospital in this high-risk population, urgent revascularization must be considered. Immediate cardiac catheterization must be performed to delineate the location and severity of obstructive coronary lesions and assess ventricular function. In experienced hands, these studies can be done with minimal risk. The need to proceed with immediate revascularization can then be made, depending upon critical evaluation of the patients' clinical status, risk factors, coronary anatomy, mass of compromised myocardium, time intervals, etc.

The operative risks and surgical results must be reviewed when considering the operative management of acute myocardial infarction. Comparable data are difficult to obtain because of the relatively small number of patients surgically treated, the wide range in time intervals between infarction and revascularization, and the presence of various complicating factors, including cardiogenic shock, refractory malignant arrhythmias, congestive failure, continued pain suggesting extension of infarction, etc. Likewise, the surgical approach to this problem in reported series has varied widely. Some groups have managed these patients with portable cardiopulmonary bypass or intra-aortic balloon augmentation for temporary cardiodynamic support, with or without the presence of true refractory cardiogenic shock.

In collected series of 87 patients urgently revascularized during various phases of acute myocardial infarction without true cardiogenic

shock, the operative mortality was 10.1%. (Table I) At first glance, this would seem quite excessive when compared to the 4% overall mortality of patients with myocardial infarction. It compares quite favorably, however, to the 15% hospital mortality of all patients admitted to coronary care units.¹¹ This group of patients is certainly highly selected and is a markedly accelerated risk group. Many of these patients presented with prolonged duration of chest pain indicating continuing infarction extension, early significant hypotension which responded to aggressive vasopressor support, or transient refractory arrhythmias occasionally eventuating in cardiac arrest requiring resuscitation. Eighty-four percent of the operatively treated patients who survived are angina free and/or in

TABLE II
Symptomatic Relief in Myocardial Revascularization of Acute Myocardial Infarction
(Without Cardiogenic Shock or Intractable Arrhythmias)

Author	No. Surviving Patients	Angina Free or NYHA Class I%
Keon (16)	7	6
Cheanvechai (5)	35	30
Reul (26)	10	7
Scanlon (28)	7	6
Bolooki (2)	5	4
Isch	3	3
	67	56 = 83.5 %

New York Heart Association Class I from four months to two years postoperatively. (Table II)

We would propose, therefore, that emergency myocardial revascularization can be performed in appropriately selected patients in the face of an acute coronary occlusion in an attempt to reverse or reduce cardiac muscle damage. As Braun-

wald so succinctly summarized in a *New England Journal of Medicine* editorial:³

It is now fair to accept the position that just because myocardial tissue lies within the distribution of a recently occluded coronary artery does not mean that it is necessarily condemned to death.

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Reoperation for Failure of Coronary Artery Bypass Surgery (The Role of Mammary Artery Grafts)

HARRY SIDERYS, M.D.
Indianapolis

CORONARY artery bypass surgery has now been applied for the treatment of symptomatic arteriosclerotic heart disease for approximately ten years. Our first operation was performed at Methodist Hospital in 1968 and since that time over 1,500 patients have had coronary bypass surgery.

It is rare for a patient who has had coronary bypass surgery to require reoperation, but, on occasion, closure of vein grafts or new disease is associated with severe symptoms and surgery is necessary.

This report describes the author's personal experience with eight patients who required a second operation (including the first patient operated on in 1968) and includes late follow-up information.

Clinical Data

Eight patients had severe angina due to closure of the vein grafts or new disease. In six patients, the symptoms were caused by occlusion of vein grafts, usually the graft to the left anterior descending coronary artery; in one patient, new disease caused the symptoms, and in the last patient both problems were present. The second operation was performed from two months to four years after the original operation with a mean of one year after the first operation. In one patient, the second operation was a triple vein graft, in another a single vein graft, and in six patients mammary arteries were used for direct anastomosis. (Table I)

From the Methodist Hospital Graduate Medical Center, 1604 N. Capitol Ave., Indianapolis 46202.

The reason for the failure of the original vein grafts is not clear. In each of the patients in whom the original grafts failed and reoperation was necessary, measured blood flow was adequate (more than 40 cc/min) and the recipient artery was not diffusely diseased. In two patients, the failure occurred late after angiograms demonstrated postoperative patency. These factors suggested that vein graft fibromuscular hyperplasia may have been the cause and encouraged me to use a mammary artery bypass for the second operation.

Results

All eight patients survived the operation and were discharged without complications. Two late complications occurred. One patient

suffered a cerebral hemorrhage related to coumadin therapy, from which she recovered. Another patient required aortic valve replacement secondary to aortic dissection nine months after his second operation and is doing well.

All patients have been followed from nine months to four years and have been interviewed and examined by their cardiologists. All are improved. Three state they have angina with exertion, but all state the angina is less than before surgery. The remaining five deny angina.

Postoperative angiography was carried out in five of eight patients operated upon. Three mammary arteries and four vein grafts were used in these five patients and they were all patent at postoperative study.

TABLE I

NAME	SEX	AGE	FIRST SURGERY			SECOND SURGERY			COMPLICATIONS OR DEATHS	ANGINA
			DATE	SURGERY AND VEIN GRAFT TO	POST-OP STUDIES	DATE	SURGERY	POST-OP STUDIES		
S. P.	M	55	11/68	R. C.	OCCL. V. G. (R. C.) NEW DISEASE CIRC. & L. A. D.	5/72	3 V. G.	3/73 3 V. G. PATENT	NONE	NO
T. C.	F	54	1/72	L. A. D.	OCCL. V. G. (L. A. D.)	9/72	MAMM TO L. A. D.	3/73 MAMM PATENT	NONE	NO
W. P.	M	44	2/73	L. A. D.	V. G. PATENT NEW DISEASE (R. C.)	12/75	V. G. RT.	12/75 BOTH PATENT	NONE	NO
J. T.	M	51	5/73	L. A. D. DIAG R. C.	OCCL. V. G. (L. A. D. & DIAG)	6/74	MAMM L. A. D.	8/74 MAMM PATENT RT. V. G. PATENT	NONE	SOME WITH EXERTION
M. G.	F	44	11/73	L. A. D. R. C.	OCCL. V. G. (L. A. D.)	6/74	MAMM L. A. D.	NO P. O. STUDY	NONE	NO
J. R.	M	54	2/74	L. A. D. R. C.	OCCL. V. G. (L. A. D.)	6/75	MAMM L. A. D.	11/75 MAMM PATENT V. G. PATENT	NONE	SOME WITH EXERTION
C. S.	M	48	10/74	R. C. L. A. D. CIRC DIAG	OCCL. V. G. (ALL)	6/75	MAMM L. A. D. MAMM RT. COR	NO P. O. STUDY	NONE	SOME WITH EXERTION
S. L.	F	58	7/75	L. A. D.	OCCL. V. G. (L. A. D.)	11/75	MAMM L. A. D.	NO P. O. STUDY	NONE	NO

Discussion

This is a small number of patients and represents a small percentage of patients who have angina after bypass surgery. It is estimated that 10% of patients will develop angina after coronary surgery while less than one percent of patients will require reoperation.¹ Only those patients who had incapacitating angina with anatomically favorable arteries and lesions were considered for repeat surgery. Patient reluctance to be reoperated on will keep the number small. Even with these restrictions, there remain a few patients who may be considered for reoperation. This study would suggest that, when carefully chosen, patients can be reoperated on with reasonable mortality and some benefit. Although all patients were improved, three patients

had some residual angina and in two of these patients all the grafts were patent. Winkle² and Adam³ have also found that recurrent angina is more common after reoperation than after primary surgery.

Selection of patients for reoperation will result in a number of patients whose vein grafts should have stayed open—i.e., those in whom the distal artery is not diffusely diseased and in whom vein graft flow was high. In these patients the problem may have been the vein itself, possibly fibromuscular hyperplasia. For this reason, a mammary artery bypass graft was used whenever possible.

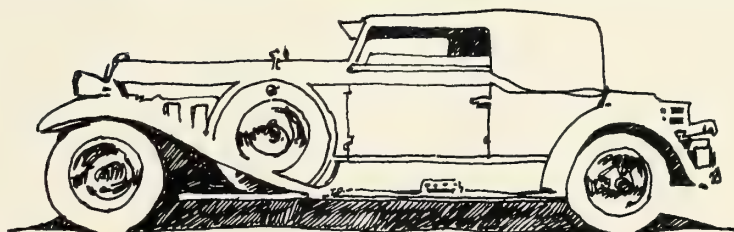
Reoperation should be considered on patients who are incapacitated by angina following surgery and who have favorable anatomic factors associated with occluded vein grafts or new disease.

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Addendum

Since the preparation of this manuscript two more patients have been operated upon with satisfying results. Both have had postoperative angiograms which showed the mammary artery and vein grafts to be patent.



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ment of Pain—Nursing Looks at Pain; Control of Pain by Anesthesia, Drugs, Hypnosis, Biofeedback/Concurrent Session B on Bioethics: A Deeper Look at Cancer—Bioethics and the Health Care Team; Ethical Considerations in Research; Ethical Considerations in Treatment; Ethical Considerations in the Prolongation of Life/Concurrent Session C: Advances in Continuing Care and Rehabilitation—New Emphasis in Cancer Control; Education for Patient and Family; Home Care and Self Care: What's New/Problems of Sexuality in the Cancer Patient; A Philosophy of Living/Meeting Patient Needs for Information—Understanding and Interpreting the Causes of Cancer; Achievements in Detection and Diagnosis; Achievements in Treatment; Quackery: The Dreadful Delusion; Implications for Practice.

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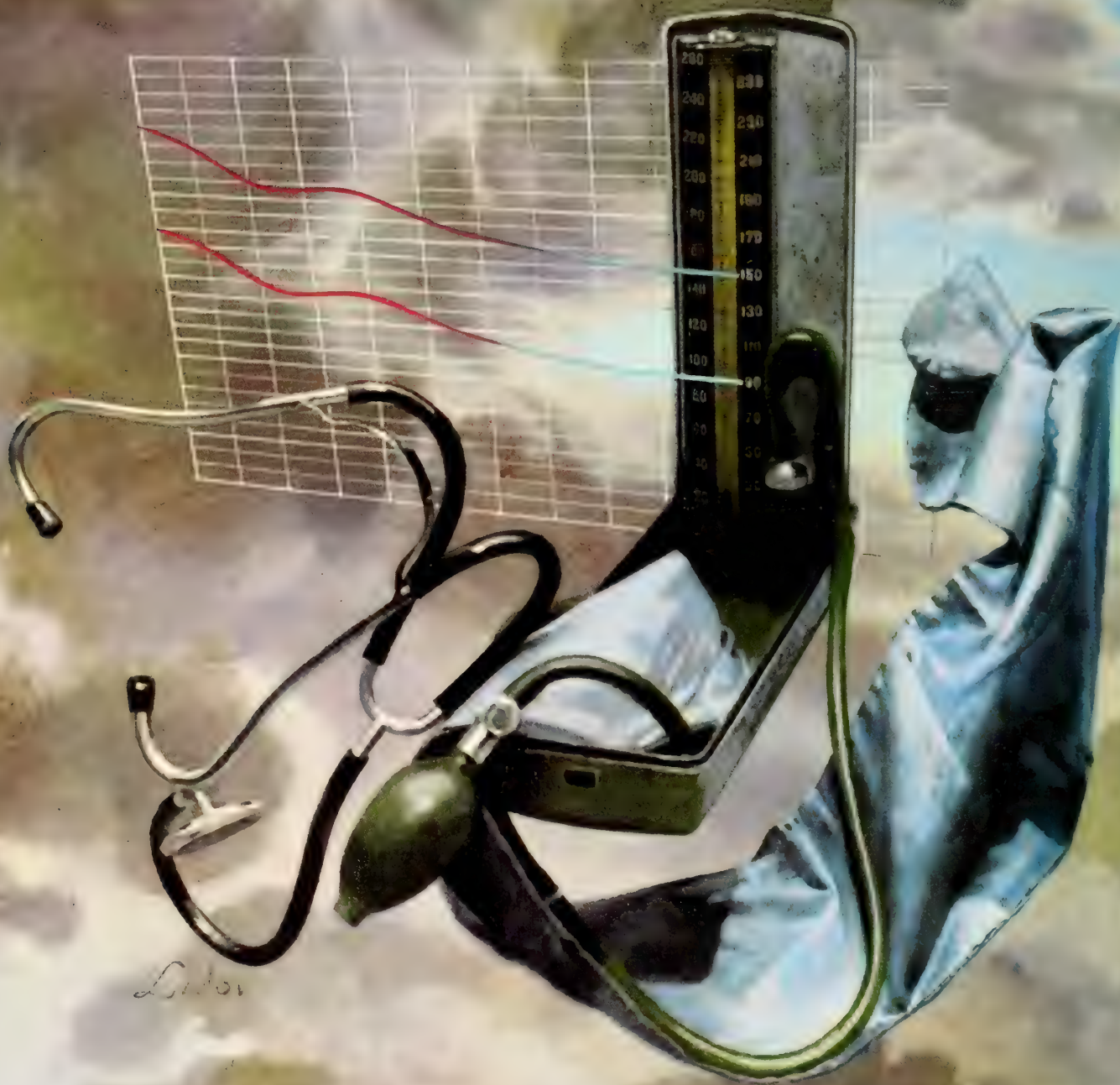
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once-daily antihypertensive diuretic

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma, allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing

age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth,

hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References:

1. Dornfeld L, Kane R: Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18: 527-533, 1975.
2. Data on file, Medical Department, Pennwalt Prescription Products.



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* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium[®] (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

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***INDICATIONS.** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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The Early Identification of Cerebral Palsy

Introduction

IT is sad but true that many developmentally handicapped children in the state of Indiana are never referred to the many excellent rehabilitative resources available in their local communities. In addition, of those who are referred, many are referred at too advanced an age for optimum therapeutic results; i.e., they may be already too crippled to enjoy the benefits of maximized developmental potential if therapy had started earlier.

The responsibility for early referral, in almost all cases, rests on the shoulders of the child's personal physician. He is the only trained professional who has early, continuing contact with children and is in a position to recognize aberrant development.

The reasons for delayed recognition and late referral are several-fold. First and foremost, many physicians are uncomfortable when forced to deal with the problems of child development. Medical schools, internships and residency programs have been shockingly deficient in not including developmental pediatrics within the medical curriculum. Hence, when faced with problems related to slow de-

Life is not a matter of holding good cards, but playing a poor hand well.

—Robert Louis Stevenson

velopment, the physician gets backed into a corner by his lack of knowledge and often suggests to the parents, "He'll grow out of it. Don't worry." However, this advice is often wrong, just as children don't "grow out" of anemia, congenital heart disease or other more familiar biomedical problems.

Second, many children are not referred to available community rehabilitative resources because of incorrect belief that therapy cannot help these brain damaged and/or retarded children. This attitude may prevail because physicians are accustomed to thinking in terms of curing disease. Chronic handicaps don't fit well into this medical model. Thus, we have to adjust our goals in terms of maximizing potential and minimizing handicap, if we are going to identify these children early and refer to the appropriate resources.

Finally, children with chronic developmental disabilities are often seen as devalued human beings. This probably results from our culture's obsessive value bias towards youth, the physically attractive, the unblemished skin, the agile body, and our almost Puritanical abhorrence of dependency. Thus, to be strong advocates of the handicapped

demands making alterations in our value systems.

Cerebral Palsy—Incidence

Cerebral palsy is the most frequent cause of permanent physical handicap among children. Its incidence in the United States, according to various studies, ranges from 1.6 to 5 per 1,000 population under 21 years of age.^{1,2,3} It is estimated that presently there are close to one half million children afflicted with cerebral palsy in this country.

In an area of 100,000 population, seven infants destined to have cerebral palsy are born each year. Of these:⁴

- One will die early.
- One will be overwhelmingly incapacitated by neuromuscular difficulties.
- Two will be additionally disabled by mental retardation.
- One will have so mild a deficit as not to require special treatment.
- Two will have moderate neuromotor difficulties but will be sufficiently intelligent to actively participate with skilled therapists. (This is not to suggest the more retarded cerebral palsied children cannot benefit from therapy; it is meant that their active participation may be less.)

From the Department of Pediatrics, Indiana University School of Medicine, The James Whitcomb Riley Hospital for Children, Indianapolis 46202.

Cerebral Palsy—Definition

Cerebral palsy is defined as:

1. A disorder of movement and posture due to a defect or injury of the immature brain.⁵
2. It comprises motor and other symptom complexes caused by a non-progressive brain injury.⁶
3. The leading diagnostic sign is a disorder of motor function which is secondary to a static brain injury that has occurred prenatally, perinatally or postnatally, as well as in infancy and childhood.⁷

Of most importance in this definition is the non-progressive nature of the brain injury. Thus, although contractures may develop from increased muscle tone and decreased motion, in cerebral palsy this does not represent progressive central nervous system disease but rather maturation and change imposed upon an already damaged brain.

Early Identification— The Pregnancy

Sir Thomas Browne has stated, "We live, move, have a being and are subject to the elements and the malice of disease in that other world, the truest microcosm, the womb of our mother."

We should first examine, then, the variables that contribute to make a pregnancy high risk for the development of neurological impairment in the offspring. First and foremost is the variable of being poor. As we examine the data on the events of reproduction, it becomes clear that almost every complication of pregnancy, labor and delivery which is potentially damaging to children is excessively prevalent among economically depressed populations and particularly among those further handicapped by ethnic difference.

Unfortunately, it is not possible in this article to describe in detail the variables of pregnancy that combine to make the mother at high risk medically and the infant vulnerable to central nervous sys-

tem damage. A good reference, however, is: Nesbit et al., *Maternal and Child Health Care Index, American Journal of Obstetrics and Gynecology*, 103:972, 1969.

The most important points to remember are that high risk pregnancies must be identified as such, they should be carefully monitored, and the offspring should be watched closely for evidence of aberrant development.

It is important to note that children who are neurologically or developmentally handicapped and who come from poor families do less well than comparably damaged offspring of more affluent families with respect to their eventual intellectual and adaptive status. Thus, poor children with neurological handicaps will often require extra special attention and more vigorous rehabilitative intervention.

Cerebral Palsy— The Perinatal Period

The labor, delivery and immediate newborn period represent critical periods during which the fetus or newly born may experience hypoxic episodes that may result in brain damage. The Apgar score has proven to be a useful device for portraying the severity of the events surrounding birth. Apgar scores can be interpreted as follows:

1. The normal Apgar score is 7-10.
2. Apgar scores of 4, 5 and 6 represent mild to moderately distressed babies. Generally, these babies are cyanotic, have none or poor respiratory efforts and are nearly flaccid. They usually have good heart rates and good reflex irritability.
3. Apgar scores of 0, 1, 2 and 3 represent severe distress.

There is a very strong correlation between the newborn's Apgar score and his subsequent developmental status. For example, for babies with Apgar scores of 3 or less who weigh less than 2,000 grams, roughly 21% will have clinically demonstrable neurological abnormalities when examined at 12 months.⁸ Thus, a

low Apgar score should arouse the physician's suspicion of possible central nervous system damage and sensitize him to monitor the development of the infants very closely.

Examination of the newborn baby should include a neurological evaluation in addition to the general physical examination. Special points to notice that may suggest neurological impairment are the following:

1. State of arousal—unusually depressed or unusually jittery.
2. Weak or feeble cry or perhaps none at all to stimulation.
3. Opisthotonus.
4. Abnormal spontaneous movements such as myoclonic jerks or convulsions, asymmetric movements, or perhaps none or markedly diminished spontaneous movements.
5. Abnormal muscle tone—marked hypertonus, marked hypotonus, asymmetric tone.
6. Lack of obligate automatism (full-term babies)—poor suck and rooting, absent moro response, lack of palmar and plantar grasps.
7. Reflexes—absent, exaggerated (4+) or asymmetric.
8. Poor feeding—usually due to poor suck or difficulties in coordinating sucking and swallowing.
9. Periodic bouts of apnea (in full-term babies).
10. Tachypnea in the absence of pulmonary or cardiac disease.

Cerebral Palsy— The Infant under Six Months

In examining the young infant for signs of cerebral palsy, the physician will need to be more in tune to the infant's performance and functional status than to the findings on a formal neurological examination. He must always remember, in addition, that the neurological status may appear to

change, i.e., the infant who is initially floppy may become progressively more spastic. This does not mean that the neurological impairment is progressive but, rather, reflects maturation superimposed upon an already damaged brain.

The first six months represent the most difficult period in which to identify cerebral palsy unless the damage is unusually severe. However, several clues are available:

1. Asymmetry of movement.
2. Persistence of clenched fists later than 5-6 months of age.
3. Parental observation of handedness (handedness does not usually develop until much later—usually between 15-24 months).
4. Early rolling over—may represent hypertonus with opisthotonic posturing.
5. Excessive hypotonia or hypertonia.
6. Inability to roll from stomach to back purposefully by 6 months.
7. Obligatory tonic neck reflex—many infants under 6 months of age demonstrate a tonic neck reflex when lying on their back and the head is suddenly turned to one side. A positive tonic neck reflex is extension of the arm and leg on the chin side and flexion of the extremities on the occipital side. However, a normal infant will resist this position and actively assume a neu-

tral position with the arms and legs. A neurologically impaired infant may not be able to break down this posture despite active crying for 30 seconds or more.⁹

Cerebral Palsy— The Child over Six Months

As would be expected, the identification of cerebral palsy becomes easier as the child becomes older. However, inordinate delay should not occur. In almost all cases, except the very mild, the diagnosis should become apparent between 6 and 15 months. The following should serve as guidelines:

1. Delay in motor milestones—
 - a. Not rolling prone to supine by 6 months.
 - b. Not sitting alone steadily by 9 months.
 - c. Failure to develop a neat pincer grasp by 15 months.
 - d. Failure to walk alone well by 15 months.
2. Preferential use of one hand.
3. Athetotic movements.
4. Excessive hypertonus or hypotonus.
5. Hyperreflexia or reflex asymmetry.
6. Persistence of tonic neck reflex and/or moro response beyond 6 months of age.
7. Scissoring position of the legs when the child is elevated vertically.
8. Tight hip adductors and/or tight heel cords.

Cerebral Palsy versus Mental Retardation

Sometimes the distinction between global mental retardation and cerebral palsy can be difficult. This is especially true in the early months when both conditions may present with hypotonia and delayed motor development. This should not be of major concern to the primary care physician; he has done his job well by the mere recognition of developmental trouble. By no means should he delay referral until he is sure of the diagnosis. Refer early! Therapy and refinements in the diagnostic process can go on simultaneously.

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A Section on Medical Schools was established by the House of Delegates at the AMA's 30th Clinical Convention in Philadelphia. Membership will consist of the dean of each approved medical school and three members of each administration or faculty who will be appointed by the dean. The Section on Medical Schools joins the Resident Physician Section and the Medical Student Business Session as special sections of the House closely allied to medical education.—In Brief . . . A Summary of AMA Medical and Health News.

Thyroid Hormone and Breast Cancer

THE physicians and basic scientists who comprise the membership of the American Thyroid Association have been concerned by the public reaction to a recent widely publicized study purporting to demonstrate a strong association between thyroid hormone treatment and prevalence of breast cancer. As a result of this publicity, many patients have inquired if they should discontinue thyroid hormone treatment which was prescribed for well-established reasons.

Implicit in the article describing this study, and in the accounts thereof transmitted to the public by the media, was the suggestion that the taking of thyroid hormone somehow causes an increased risk of developing breast cancer. In the light of present knowledge and on the basis of the recent article itself, there are several reasons why any such conclusion would presently be dubious, at best. First, there are a number of important pieces of in-

formation omitted from the original account. Among these are the nature of the underlying thyroid disease or other disorder for which thyroid hormone treatment was being taken; the dosage and precise nature of the thyroid hormone being taken; the racial and ethnic mix of the population studied, the frequency and type of co-existent disease; other hormone therapy that the patients may have been taking; and the methods used to confirm the diagnosis of breast cancer. Most important, even if an association between thyroid hormone therapy and breast cancer were eventually to be proven, it would remain to be shown whether the causative factor was the thyroid hormone treatment itself or the disease or diseases for which such treatment was being given.

Patients with mild or moderate hypothyroidism, if left untreated or withdrawn from treatment, are prone to develop fatigue, impaired intellectual and work capacity,

diminished fertility, weight gain and cold intolerance. In patients with severe thyroid deficiency, more serious symptoms and even risk to life may result. Furthermore, substantial evidence indicates that over longer periods hypothyroidism predisposes to arteriosclerotic heart disease. These widely recognized consequences of hypothyroidism stand in striking contrast to the tenuous nature of the proposed relationship between thyroid hormone treatment and breast cancer.

Therefore, the American Thyroid Association strongly recommends that those patients who are currently taking thyroid hormone for the treatment of either goiter or definitely diagnosed hypothyroidism should continue to take it, and those who have been advised that thyroid therapy should be started for those reasons should not hesitate to begin treatment.—**Press release from the American Thyroid Association, Inc., December 1976.**



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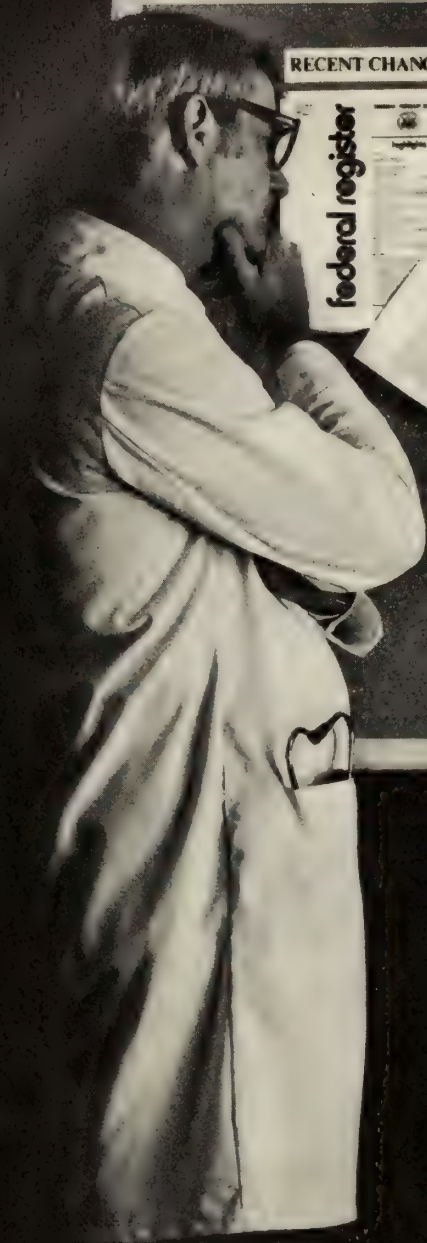
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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Associate Editors: A. W. Cavins, M.D., R.R. 25, Box 172, Terre Haute 47802; Lall G. Montgomery, M.D., R.R. 1, Box 202, Gaston 47342; Samuel R. Mercer, M.D., 702 Medical Center Bldg., Fort Wayne 46802; I. W. Wilkens, M.D., 4820 E. Pleasant Run Pkwy, N. Dr., Indianapolis 46201; W. D. Snively, Jr., M.D., R.R. 1, Box 277, Evansville 47712.

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3935 N. Meridian, Indianapolis, Ind. 46208

Medical Care in Jails

INDIANA is one of the six states in which a study of medical care and health services in jails is being conducted by the state medical association under a grant to the American Medical Association from the Law Enforcement Assistance Administration.

Pilot studies have now been under way for one year. The object of the project is to gather data and study conditions about jails and to formulate standards which can be utilized in a voluntary certification program for jails.

In Indiana seven county jails were chosen for study. The jails in the two largest counties, Marion and Lake, and a cluster of five counties, all small and contiguous (Morgan, Monroe, Brown, Owen and Greene) were included.

Physical examinations were done for all inmates of the small jails

and for 50 inmates in the large ones. A medical history and urinalysis, skin test for Tbc, and blood tests for syphilis and hepatitis were included.

The study has also included conferences with many groups and individuals in order to learn the problems of jail management and to specify the financial and personnel difficulties.

A State Advisory Committee, divided into four groups, will attend to problems in financing, public relations, education and training and program development. This committee will do its work now that the baseline studies are being completed.

The interim report lists the following impressions:

1. No evidence of severe health problems has been found. As would be expected, there is ample evidence of alcohol abuse and to a lesser degree ordinary

drug abuse. Also much evidence of poor dental hygiene and bad teeth.

2. No indications of acute health problems which have not been handled with dispatch and in an acceptable medical way.

3. Jails could be improved to facilitate good medical care.

4. All jail personnel are found to be sensitive to the need for good medical care. They have been alert to health problems, especially emergencies. They are interested in obtaining more para-medical training.

5. Sheriffs and their personnel have been receptive to suggestions for better record keeping, for a unified history and examination form, for medical training programs and for development of a jail manual for the medical and dental section.

6. The Indiana Jail Project is

developing plans for medical and dental services on a regional basis.

Difficulties in the program of improving the medical care in jails are recognized as follows:

1. *Financing.* Everything costs money and especially improvements. The public, in general, considers all jail inmates as guilty of something and to some degree undeserving of good treatment.

2. *Inertia in the System.* When, as and if plans are made for changes, the implementation will require a long time and dedicated effort.

3. *Volunteerism.* The AMA project is a voluntary one. An extraordinary amount of drive is required to maintain progress in social change, no matter how worthy.

The Advisory Committee's summary is as follows: The AMA Jail Project is completing its first year with a solid base of accomplishment which will enable it to move into a second year where there will be implementation of tested Standards for Medical Care and Health Services in Jails and expansion of the program from the initial seven-county pilot program. The results of the first year's efforts are encouraging. The positive attitude of the participating physicians, county sheriffs and jail personnel have contributed greatly towards Indiana's Jail Project being able to keep up with the total national program and to be competitive with the other five states in the pilot program. Much remains to be done and we cannot be assured of success but, with the impelling force of

Federal Court mandates, the honest desire of the general public to be humane, the support of the physicians of Indiana and persistent effort on the part of all those now involved in it, the program will move forward with benefits accruing to all.

The Joint Commission on Prescription Drug Use

WHAT was, on good authority, called a "unique collaboration of public and private interests" came to life in Washington, D.C., recently.

The new Joint Commission on Prescription Drug Use is an independent panel created under drug industry auspices at the request of Senator Edward M. Kennedy for the purposes, as expressed by him, of setting up a system for discovering the true incidence of adverse reactions and the very real benefits of appropriate drug usage and even new uses for old drugs.

Months of work and cooperation between the Pharmaceutical Manufacturers Association, various pharmaceutical firms and Senator Kennedy's staff resulted in a request for nominations for membership on the Commission from other professional associations.

Final selections were made by Senator Kennedy, by Theodore Cooper, M.D., assistant HEW secretary for health, and by David Hamburg, M.D., president of the Institute of Medicine, National Academy of Sciences.

The final result is a Commission of 18 members—physicians, pharmacists, pharmacologists, attorneys, hospital administrators and representatives of industry and the general public.

The Commission has a three-year charter and will be funded principally by the PMA to the tune of about \$250,000 per year. The medical section of the PMA has for several years been studying a method of surveillance of drug usage, drug reactions and drug efficacy, but it was Senator Ken-

nedy's challenge expressed at the annual PMA meeting in 1976 that produced the Commission and the support for its activities.

The Commission plans to assemble drug use data, design a mechanism for post-marketing surveillance, and develop a format for the periodic reporting of drug experience to the public and the medical community.

Senator Kennedy summed up the mission of the new Commission when he stated that the panel has a "much broader mandate" than reporting adverse drug reactions alone.

Editorial Notes . . .

With the recent addition of 16 new family practice residencies there are now a total of 303 in the U.S. There are more than 4,600 residents now in training. The American Academy of Family Physicians expects that more than 340 residencies will be in operation by the end of 1977. The goal is to have one fourth of all medical school graduates each year entering FP residencies by 1980.

Sight impaired students receive many ingenious aids at Ball State University to maximize what visual acuity they possess. The read-write system is a television camera which reproduces text from a book, microfilm or microfiche in enlarged form on a monitor screen. Also, blind or severely impaired students can use the speech compressor which makes it possible to listen to tapes played two or three times as fast as normal. A computer prevents the "Donald Duck" distortion which is characteristic of accelerated speech. Tapes may be recorded by the compressor and then played back on ordinary equipment at home. For notetaking the visually impaired students have the use of a braille writing machine.

Contributions to the Leukemia Society of America are up this year by almost \$1 million. The Society's



"YOU CAN EAT ANYTHING. JUST DON'T SWALLOW IT."

research program will be broadened as a consequence. Expenditures for patient services and for public health and professional education will all be increased.

Dr. Jan Dlouhy, president of Lederle Laboratories, cautions against forming a European-type medical service system with all its mistakes. He predicts that, for instance, legislators will focus on the profit-making sector of health care and financially starve the drug industry, even though drugs take up only 9.1% of the total health care bill. Also, he says, if pharmaceutical companies such as Lederle, research oriented companies, have to compete solely on government-dictated price, they will be forced to review their commitment to research.

The Pharmaceutical Reimbursement Advisory Committee, which is

the government's advisory group on the cheap drug program, is reported as being uncomfortable with the adequacy and accuracy of data provided to them for their determinations. One member visited the data producing facility and was impressed by the number of sources of error. In fact the entire process is stupid. In a competitive economy any drug properly made will cost almost exactly the same as any example of the same drug made by anyone else. In drug making quality control is the only thing a maker can skimp on to reduce the cost.

Monroe E. Trout, M.D., director of medical affairs for Sterling Drug, has proposed that manufacturers of products on which the patent has expired be required to pay a royalty to compensate the originating company and provide funds for future

research. The interval between the patenting of a new drug and its release for sale by the FDA has grown so long that it is difficult for the patent owner to recoup the greatly increased costs of discovery and perfection. This seriously limits the amount of money available for research and discovery of new drugs.

The U.S. prescription drug industry is now spending more than \$1 billion a year in pharmaceutical research. Partly due to inflation of prices, the cost of developing a single new chemical entity drug, which was \$1.2 million in 1962 and \$11.5 million in 1972, was up to \$24.4 million in 1974. The greatly increased cost of clinical trials, more elaborate toxicology studies required by regulation and more complex research techniques are all contributory. ◀



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TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

Introduction

In my opinion, the changes in the federal gift and estate tax provisions which were made by the Tax Reform Act of 1976, can be best understood by incorporating the changes into the former framework of the law. Thus, I shall, in the next few articles, put the changes in perspective by weaving them into the law which you already know. To do so, I shall commence with the gift tax law. And, as a preface to my discussion, I shall observe that most of the gift and estate tax changes which were brought about by the Tax Reform Act of 1976 are applicable to transfers (or other activities) which occur after Dec. 31, 1976. Further, all of the references in this article which are to a "section" or to the "Code" are to the Internal Revenue Code of 1954.

Gift Taxation

As to the computation of taxable gifts, the new provisions have done nothing to change: (1) the concept of *what* a gift is; or, (2) *when* a gift has been made; or, (3) the manner in which gifts are *valued*. Therefore, if I make a donative transfer of stock to a child of mine, the transfer still is a gift, and the value of the transfer is the stock's fair market value at the date of the gift. Further, even though three of the five sections which provide exclusions from the gift tax have been amended, only one of them has been significantly changed. In addition, in general, each of the three changes are beneficial to taxpayers.

That is, we still have, under section 2503, the \$3,000, per donee,

per year, exclusions for gifts of present interests. And, in this regard, we still have the \$3,000 exclusions under section 2503(c) for gifts of future interests to minors, if certain conditions are met.

Also, we still have exclusions for transfers which are made pursuant to exercises of limited powers of appointment under section 2514. That is, if the holder of a limited power of appointment exercises the power in favor of another person, then there still is *no* taxable gift. However, the new law removed the language in section 2514 which stated that: a disclaimer or a renunciation of a general power of appointment is not a release of the power. The purpose of this deletion was not to make such disclaimers or renunciations automatically taxable, but instead, the purpose was to allow the gift tax result of such disclaimers and renunciations to be treated under new provisions, in new section 2518. In general, section 2518 provides a federal method for making such disclaimers and renunciations so that, if the new procedure is followed, then these actions will continue to be non-taxable.

Further, we still have the statutory exclusion under section 2515 (and other exclusions under the Regulations, rulings, and procedures) for transfers of *certain* property into joint tenancies with rights of survivorship or into tenancies by the entireties. That is, we still have gift tax exclusions for the creation of such tenancies, between *spouses* in *real estate* and for the creation of such tenancies between any persons in bank accounts, in U.S. government bonds, and in stock brokerage accounts. Again, these transfers *were not* and *still are not* subject to gift taxation. For that matter, we still have the election by spouses to *treat* transfers of real estate by either of them to the other, with rights of survivorship, as *taxable* for gift tax purposes. However, now if one spouse makes the election to have such real estate be subject to gift taxation, then the value of the gift is to be treated as one half

of the value of the spouses' joint interests. Thus, the new law has eliminated the need for utilizing actuarial computations in order to determine the value of such a gift. As a result, when one spouse makes a transfer to that spouse and to his or her younger spouse, as tenants by the entireties, and then makes the election to have the transfer subject to gift taxation, the value of the taxable gift will be less than it would have been under the former law. That is, the prior law generally required the use of an actuarial table in order to determine the value of the gift, and such a gift, to a younger spouse, would be a gift of more than one half of the value of the joint interests. In addition to this change, the new law provides that if such an election (to have the transfer be subject to the gift tax) is made, then the election will apply to each later addition which is made to the value of the property.

As to section 2516 (which concerns transfers between spouses, under a written separation agreement, where divorce occurs within two years after the execution of the agreement), we still have this section intact. Thus, such transfers are still excluded from gift taxation.

Also, we still have exclusions under section 2517 for transfers by employees of their interests in qualified annuities. However, *now* this exclusion has been *expanded* in order to include transfers—that is, gifts, by an individual who has either established as a self-employed person an H.R. 10 plan, or established an individual retirement account (an IRA). Thus, such persons now may exclude for gift tax purposes the value of such a fund, to the extent that such value is attributable to the self-employed person's or IRA person's contributions which were deductible for income tax purposes. Thus, persons who establish either H.R. 10 plans or IRAs now are treated in this respect, the same as employees—in that owners of H.R. 10 plans or IRAs may exclude from gift taxation transfers of certain interests

which such persons have in such plans. However, to the extent of the value of nondeductible or voluntary contributions, such value is subject to the gift tax (as in the case of employees).

Thus, to recapitulate, you still compute *gross gifts* in the same manner as before—namely: total gifts less exclusions. And, the only significant differences are that the law now:

1. Provides a specific method for

disclaiming and renouncing gifts;

2. Provides that if one spouse makes a gift of real estate to that spouse and the other spouse as tenants by the entirety and the first spouse elects to have the transfer taxable, then the value of the gift will be treated as one half of the value of the spouses' joint interests; and,

3. Provides that gifts of a self-

employed individual's interest in an H.R. 10 plan or a gift of an individual's interest in an IRA will be excluded from the gift tax to the extent that the value of the fund is attributable to the individual's deductible (for income tax purposes) contribution to the fund.

In my next article I shall discuss the changes in gift tax deductions.

About Our Cover

The ornamental gateway, known as The Arch, is a favorite subject of photographers in wintertime at DePauw University in Greencastle. It was a 20th anniversary gift of the class of 1890 and joins a cherished list of DePauw traditions including the Columbian Boulder, the Scarritt Fountain, the Owl, and, of course, soon-to-be-restored East College and its clock tower and bell.

The 139-year-old independent university, known as Indiana Asbury for its first 45 years, has undergone a dramatic change in its campus skyline. An \$8.1 million Performing Arts Center was dedicated last year. In 1972 students moved into an ultra-modern \$7.2 million Science and Mathematics Center. A new \$5.5 million Recreation and Athletic Center, promoting life skills, is on the drawing boards.

A good liberal education is another tradition at DePauw where 67% of the faculty hold doctorates and good teaching in a hospitable environment is paramount.

DePauw presently invests or makes available over \$3 million in all kinds of financial aid to more than half its 2,300 students so that they may have the benefit—if they desire it—of excellence in the College of Liberal Arts, the School of Music and the School of Nursing.

New programs such as Careers in Business and Public Service, the Wilderness Program, and Winter Term are geared to meet the needs and expectations of today's college student, but in a liberal arts context.

DePauw has historically provided the undergraduate training of many of Indiana's doctors in its pre-professional pre-med program. The School of Nursing, growing from a first year enrollment of five in 1955, has now reached 160 members with graduates distinguishing themselves throughout the state and nation.

The School of Nursing utilizes teaching, classroom and office facilities of the Methodist Hospital in Indianapolis. Clinical learning opportunities are scheduled with the Methodist and Community Hospitals.

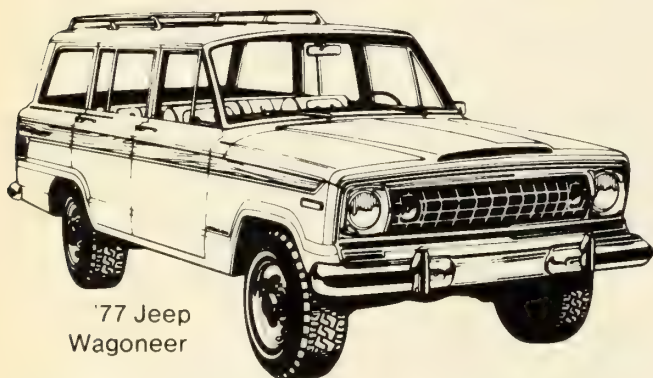
Many prospective nurses and doctors at DePauw now are propelled even more enthusiastically toward careers in medicine and health care. A month-long project period in January, called Winter Term, enables them to work and observe with sponsoring, helpful doctors and nurses in hospitals and clinics throughout the United States.

(Sixth in a series featuring the independent colleges and universities of Indiana.)

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FUTURE MEETINGS, SEMINARS, COURSES

Courses Announced by I.U.S.M.

The following programs have been scheduled by the Indiana University School of Medicine's Division of Postgraduate and Continuing Medical Education:

Mar. 1-3	Current Topics in Internal Medicine
Apr. 20-22	Radiology of the Genitourinary Tract
May 4-5	Basic Clinical Electrocardiography
May 19-20	New Developments and Controversies in Management of Carcinoma of the Breast
June 1-3	Selected Topics in Endocrinology and Metabolism (Co-sponsored by the ACP)
June 7-9	Family Practice Review
July 5-7	Family Practice Review

Information on any of these courses may be obtained by writing Mr. John Roscoe, 317 Fesler Hall, 1100 W. Michigan St., Indianapolis 46202; phone 317-264-8353.

Seventh Family Medicine Review

The University of Kentucky Medical Center announces its Seventh Family Medicine Review, Session III, for Feb. 20-26 at Lexington. Fee is \$295. For further information, contact Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington 40506.

Mediclinics Offers Course in Florida

Mediclinics announces a spring seminar, to be held in the Galt Ocean Mile Hotel, Fort Lauderdale, Mar. 7-18. Sponsored by the Florida Academy of Family Practice and Broward Medical Center, the seminar has requested approval for 50 hours' credit by the American Academy of Family Practice. Registration fee is \$300. Information may be obtained by writing or calling Mediclinics, 832 Central Medical Building, St. Paul, Minn. 55104.

Emergency Medicine Seminar Planned

The Indiana chapters of the American College of Emergency Physicians and the Emergency Department Nurses Association will present a seminar at the Airport Hilton Inn, Indianapolis, May 11 through 14, 1977. The Indiana University School of Medicine is a co-sponsor.

Fees are \$50-\$100. Information: David Gettle, M.D., 10005 Hillsdale, Carmel, IN 46032; 317-844-7105.

Midwest Clinical Conference in March

Mar. 2-5 are the dates for the Midwest Clinical Conference; McCormick Inn, 23rd and the Lake, Chicago, is the place, and the sponsors are the Chicago Medical Society and participating specialty societies. Scientific sessions, special instruction courses, exhibits and special events are planned. Twenty-five elective hours by AAFP.

For further information, write or phone Midwest Clinical Convention, Chicago Medical Society, 310 S. Michigan Ave., Chicago 60604; 312-922-0417.

Ob-Gyn Symposium at Memphis

The University of Tennessee Department of Obstetrics and Gynecology will conduct a symposium on "Endocrine Causes of Menstrual Disorders" Mar. 16 to 18 at the Hilton Inn in Memphis. Approved for 20 elective hours by the American Association of Family Practitioners and 30 cognates by the American College of Obstetricians and Gynecologists. Correspond with: James R. Givens, M.D., Division of Continuing Education, UTCHS, 800 Madison Ave., Memphis, TN 38163.

Neonatal Dilemmas Topic of Course

On April 12 and 13, Methodist Hospital, Indianapolis, will host its annual Newborn Symposium. Title of the symposium is "Major Dilemmas in Neonatal Pediatrics."

Guest faculty will include Dr. Avroy Fanaroff (Case-Western Reserve), Dr. Joan Hodgman (University of Southern California), Dr. Arthur Norins (Indiana University), Dr. Paul Perlstein (University of Cincinnati), Dr. Clement A. Smith (Harvard Medical School) and Jeryl Gagliardi, Nurse Clinician (Yale-New Haven Hospital). Among topics to be discussed will be dilemmas of nursery staffing and environment, aspiration syndromes, oxygen monitoring and appropriate skin care of the young infant.

For details, write Richard S. Baum, M.D., The Newborn Center, Methodist Hospital, 1604 N. Capitol Ave., Indianapolis 46202, or phone 317-924-8174.

Family Medicine Teachers to Gather

The Tenth Annual Spring Conference of the Society of Teachers of Family Medicine will be held in Atlanta on May 2 to 4. "Interactions in Family Medicine" will be the theme. The Peachtree Plaza Hotel will be the meeting place. Registration fee is \$50 for members and \$75 for nonmembers. Write to Mary E. Neil, 1740 W. 52nd St., Kansas City, Mo. 64114.

12th Child Care Conference Announced

The 12th Annual Indiana Multidisciplinary Child Care Conference will be held at the Marriott Inn, Indianapolis, on May 18 and 19.

The seminars and seminar leaders are Dr. Gordon Avery—Neonatology; Drs. David Carver and Martin Kleiman—Infectious Disease; Drs. Michael Cohen, Karen Hein, Ken Schonberg—Adolescence; Dr. Stanford Cohen—Pediatric Pharmacology; Dr. Henry Nadler—Genetics; Dr. Nathan Smith—Sports Medicine, and Drs. William Waring and Howard Eigen—Pulmonary Disease. Banquet speaker will be Dr. Robert Haggerty.

For further information concerning the seminars and registration, please contact Dr. Morris Green, 1100 W. Michigan St., Indianapolis 46202.

Kentucky Schedules Surgical Symposium

The University of Kentucky Medical Center at Lexington will hold the "Wangensteen Surgical Symposium" June 9 to 11. Registration fee is \$200. Write Frank R. Lemon, M.D., University of Kentucky, Lexington, Ky. 40506. ◀

The Auxiliary Reports to ISMA

Dear Doctor:



Our ISMA Auxiliary legislation co-chairmen are Mrs. Robert Schleinkofer (Karen) and Mrs. Frederick Mackel (Alfrida), from Allen County, Fort Wayne. As state chairmen, they help auxiliary members to become interested and informed about important medical legislation. They also provide a system of communication to alert auxiliary members on current medical legislation and on needed action. This month I have asked Karen Schleinkofer to share a few thoughts with you.

Chloe A. Goldsmith

Chloe (Mrs. David A.) Goldsmith
President, ISMA Auxiliary

"Meet Your Legislator" Luncheon

February 23 is the date for the Indiana State Medical Auxiliary's "Meet Your Legislator Luncheon." It will be held at the Columbia Club in Indianapolis. Each of the counties will be inviting their own legislator. An invitation coming from a constituent is acknowledged sooner than one from a group. We will be meeting our legislators on a one-to-one basis. It is a great opportunity to get acquainted with our lawmakers and to discuss any legislation before the current session.

An interesting program is being planned. At this writing we are hoping to have our AMA Auxiliary's legislation chairman, Mrs. Hoyt Gardiner, as our guest speaker.

This is a good time for those who attend the luncheon to have their teenagers act as pages for the General Assembly. A request should be sent to your legislator. We encourage everyone who is able to attend the morning session. We need to be knowledgeable about legislation, particularly medical legislation.

Karen Schleinkofer

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NEWS NOTES

Continuing Medical Education

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William Dale Boaz, Wabash	Frederick L. Kuhn South Bend
Kenneth E. Bobb, Seymour	Georgianna Lutz, Gary
Louis F. Bradley, Bluffton	Harold M. Manifold, Bloomington
Barton C. Bridge, Lafayette	Peter P. Mayock, Bluffton
Pedro Bukata, Munster	Robert L. Meissel, Terre Haute
Truman E. Caylor, Bluffton	George W. Merkle, Bluffton
Carlos A. Cespedes, Griffith	Victor C. Moeller, Fort Wayne
James J. Chen, Munster	Floyd W. Mohler, Columbus
James O. Coursey, Plymouth	Brunhilda I. Odulio, Mitchell
Christopher Deen, Merrillville	Hee Myung Park, Indianapolis
Fausto Duque, Jeffersonville	Neal Chase Pitts, Bluffton
Melvin S. Durkee, Evansville	Melvin J. Powell, Columbia City
Romeo Y. Estacio, Munster	Steven J. Rawlins, Merrillville
Michael Warren Free, Columbus	Vivencio F. Raymundo, Elwood
W. Stanley Garner, Indianapolis	Bertram S. Roth, Indianapolis
Thomas H. Gootee, Jasper	Kenneth J. Rudolph, Evansville
Malcolm B. Herring, Indianapolis	Robert H. Rumana, Bluffton
Harland V. Hippensteel, Auburn	Kenneth D. Schneider, Columbus
Phillip Eli Hodonos, Michigan City	Robert M. Seibel, Nashville
Richard G. Huber, Bedford	Burton J. Shapiro, Indianapolis
Robert E. Jensen, Fort Wayne	Mark I. Singer, Indianapolis
Harold V. Johnson, Evansville	H. Charles Smith, Bluffton
	Robert W. Stephens, Carmel
	Ralph B. Ullom, Indianapolis
	Robert F. Walter, Evansville
	Robert A. Ward, Tell City
	Jerry M. Weida, Lafayette
	Richard P. Yoder, Bluffton

Harold F. Zwick, Decatur

Hospital Medical Staffs Elect

St. Mary Medical Center, Hobart—Dr. William F. Nowlin, president; Dr. Robert R. Wylie, president-elect; Dr. Pierre Gilles, secretary; Dr. Vijay Pillay, Crown Point, treasurer; Drs. Oscar de la Paz and J. O. Carter, staff representatives to the executive committee. Dr. Robert Martino is outgoing president.

Bloomington Hospital—Dr. James H. Booze, chief of staff, succeeding Dr. Larry D. Ratts; Dr. William Cron, chief of staff-elect; Dr. Michael Bishop, secretary; executive committee members-at-large: Dr. William R. Anderson, Dr. C. R. McIntire and Dr. Glen D. Ley; chief, surgical section, Dr. James Topolpus, Jr.; chief, medical section, Dr. Theodore Megremis; chief, Ob-Gyn-Peds section, Dr. Robert E. Wrenn.

St. Vincent Hospital, Indianapolis—Dr. Robert F. Nagan, president; Dr. Thomas E. Woerner, president-elect; Dr. John A. Crawford, secretary-treasurer.

Orange County Hospital, French Lick—Dr. Marion Hagan, president; Dr. Wallace Shellenberger, vice-president; Dr. Terry Nofziger, secretary.

Elkhart General Hospital—Dr. James Miller, Wakarusa, chief of staff; Dr. Ramona Middleton, vice-chief of staff; Dr. Larry Knight, secretary; Dr. George Mark, executive committee member-at-large.

St. Francis Hospital, Beech Grove—Dr. Frank W. Fortuna, president; Dr. Robert L. Costin, vice president and president-elect; Dr. Donald H. McCartney, secretary-treasurer.

St. Mary's Hospital, Evansville—Dr. Henry Leibundguth, president; Dr. Robert L. Harris, vice-president; Dr. Kenneth J. Rudolph, secretary-treasurer; Dr. Donald P. Cobb, chief of obstetrics and gynecology; Dr. Eugene W. Austin, chief of pediatrics; Dr. Arthur Griep, chief of medicine; Dr. Robert F. Walter, chief of family practice, and Dr. Ralph F. Carlson, chief of surgery.

Continued

Diabetes Research Funds Available

The Juvenile Diabetes Foundation, 23 E. 26th St., New York City, 10010, will receive applications until March 1 for grants for diabetes research funds. Approved grants will be funded beginning Sept. 1. Write the Foundation for full particulars and application forms.

AAMA to Offer CEU Credits

The American Association of Medical Assistants, thru its Continuing Education Committee, announces a program for awarding Continuing Education Unit credit for qualified educational programs. Criteria have been established for the programs. Credit will be awarded for actual instructional hours spent in learning. Programs will be approved and credits will be certified by the AAMS national headquarters in Chicago.



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Methodist Hospital, Indianapolis—Dr. Donald L. Rogers, president; Dr. James H. Gosman, vice-president; Dr. H. Marshall Trusler, secretary-treasurer. Drs. Warren E. Coggeshall, Rogers, Hugh K. Thatcher, Jr., and John H. O. Mertz are serving on the joint liaison committee with the hospital board of trustees.

Witham Hospital, Lebanon—Dr. Ritchie Coons, chief of staff; Dr. Don Boyer, vice-chief of staff; Dr. John Saalwaechter, secretary-treasurer. Drs. E. E. Gregg, William Anshutz and Jack Lenox will also serve on the executive committee.

"Clinical Depression" Program on TV

Pfizer Laboratories and the University of Pennsylvania are presenting a five-part continuing medical education program, two parts of which will be broadcast as two half-hour programs on commercial television. The first film appeared during the last two weeks of January and the second will appear during the first two weeks of March. The title is "A Course on Clinical Depression." All necessary information and tests will be mailed directly to primary care physicians. The program is approved for up to nine credit hours in Category 1 of the Physician's Recognition Award of the AMA.

Four Named ACCP Fellows

The American College of Chest Physicians recently inducted into Fellowship Drs. Richard E. Brashear and John H. Isch of Indianapolis, Dr. Yacoub Massuda of Munster and Dr. John C. Scanlon of West Lafayette.

Judge Rules GAO Exceeds Authority

Efforts of the federal government to obtain practically unlimited financial data from Eli Lilly and Company have been denied by Federal Judge Cale Holder, who ruled that the General Accounting Office exceeded its authority when it demand-

ed all cost records involving the manufacture of various products supplied by Lilly to the government.

Booklet on Campus Drinking Offered

A booklet devoted to the problem of campus drinking has just been published by the National Institute on Alcohol Abuse and Alcoholism. "The Whole College Catalog About Drinking" is the title. Single copies may be obtained free by writing the National Clearinghouse for Alcohol Information, Box 2345, Rockville, Md. 20852. Ask for it by title and inventory No. BK72.

Miles Offers Calendar for 1977

Miles Research Products, Elkhart, will mail free on request their seven-color calendar for 1977. It includes all the major biochemical conventions. Also includes space for each day of the year on which notes and schedules may be written. ZIP number is 46514.

AAME Plans Two Certification Exams

The American Association of Medical Assistants will conduct its basic Certification Examination twice yearly. The first basic examination was held in September 1976, at which time 144 certificates were awarded, eight of them to candidates in Indiana. The Association will continue to conduct the basic exam and all three specialty exams each spring, at more than 100 test centers throughout the U.S.



DR. JOHN BEELER, president of the Indiana State Medical Association, presented a check for more than \$20,000 for the American Medical Association's Education and Research Foundation to ERF President James M. Blake, M.D. The presentation took place at the clinical convention in Philadelphia. Five dollars of ISMA dues are earmarked for this program each year.

Schedule for Upcoming NCME Programs

The Network for Continuing Medical Education Announces the following schedule of programs:

Feb. 7-20 "SPINAL CORD TRAUMA," with Alain B. Rosier, M.D., chief of spinal cord injury service, Veterans Administration Hospital, W. Roxbury, Mass., professor of spinal cord rehabilitation at Harvard Medical School, Boston.

"ANTIBIOTICS IN RENAL FAILURE," with Harold C. Neu, M.D., associate professor of medicine, associate professor of pharmacology, and head of section on infectious diseases, College of Physicians and Surgeons, Columbia University, New York City.

"BENIGN PROSTATIC HYPERPLASIA," with Earl Wendel, M.D., urologist, Passavant Hospital, Chicago.

Feb. 21-Mar. 6 "ANAEROBIC INFECTIONS, PART I," with Robert Fehety, M.D., head, Division of Infectious Diseases, Department of Medicine, University of Michigan, Ann Arbor.

"ANAEROBIC INFECTIONS, PART II," with William J. Ledger, M.D., professor of obstetrics and gynecology, University of Southern California, and director of maternal fetal medicine at Women's Hospital, Los Angeles.

"CARCINOMA OF THE PROSTATE," with Earl Wendel, M.D., urologist, Passavant Hospital, Chicago.

For more information about NCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York, N.Y. 10023.

There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

Naming Digits

I think it's important that we name, not number, the digits of the hands. Let's call them by name and easily identify them, rather than force others to start counting from some unknown point.

I say unknown, because it isn't clear when someone says "the fourth finger" if he has started counting at the thumb and means the ring finger, as most non-medi-

cal people do, or if he has started counting fingers with the index finger, the first true finger. A few physicians would start counting fingers with the index finger and designate the small finger as the "fourth finger" when talking or writing to someone.

Most start with the thumb; watch how many physicians speak of a "fifth finger" and imply that the opposable thumb is a finger.

And recently I saw a physician start counting with the small finger.

It's better to simply name them from the start, rather than number the fingers and create confusion. Many industrial clinics have insisted for some time on naming the digits of the hands.

Call them: "thumb," "index finger," "long finger," "ring finger" and "small finger," for example.

Name them. Don't number them.

3901 Lincoln Ave.
Evansville 47715

From THE JOURNAL 50 Years Ago

Since it has been demonstrated beyond the shadow of a doubt that accessory nasal sinus disease may be responsible for a large variety of ocular affections, and also that nasal sinus infection may give rise to disease elsewhere in the body, the importance of locating and eradicating such foci of infection increasingly impresses itself upon the mind of the oculist and the internist. Another fact to be taken into consideration, is that the anatomical location of the sinuses often makes diagnosis by ordinary clinical methods exceedingly difficult if not impossible. These facts make roentgenological examination a very essential procedure. Both rhinologists and roentgenologists should make more intensive efforts to correlate the x-ray findings and pathological conditions affecting the nasal sinuses, particularly the ethmoid and sphenoid cavities. It is highly important that a knowledge of the very definite aid that roentgenology is prepared to render in the diagnosis of nasal sinus disease be conveyed to rhinologists, ophthalmologists, neurologists and internists, in order that they may come to see that there is no just ground for the pessimism, so often expressed in the past, with respect to the value of roentgenological examination of the nasal sinuses. — "Roentgenological Evidence of Nasal Sinus Disease," by Drs. Albert M. Cole, Raymond C. Beeler, Lester A. Smith, **JISMA** February 1927.

Notice To Members

Have your 1977 District, County, State and American Medical Association dues been paid?

Your support is necessary if organized medicine is to continue its fight against government encroachment into medical practice.

ISMA dues are \$181; AMA dues are \$250. Please check with your local secretary to learn the amount of your County Society dues and your District dues. Indiana Medical Political Action Committee—American Medical Political Action Committee dues are \$50. IMPAC-AMPAC membership is recommended.

As part of the privileges and services offered to all members of the ISMA, you receive a year's subscription to THE JOURNAL of the Indiana State Medical Association and copies of the News Flash—without extra cost. Dues-paying members of the AMA receive a year's subscription to THE JOURNAL of the AMA, the American Medical News and the specialty journal of your choice.

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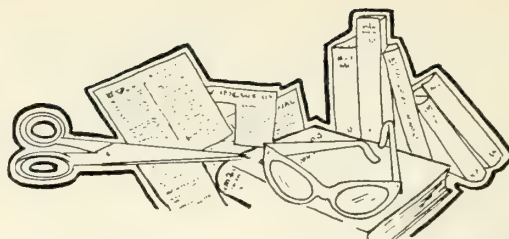
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BOOK REVIEWS

ELEMENTS OF MEDICAL GENETICS

Alan E. H. Emery, University of California Press, Berkeley and Los Angeles, 1976 245 pages.

It may be that molecular biology and the understanding of the function of deoxyribonucleic acid (DNA) as the ultimate building block of living things will be the trend in future science. Then mankind may unlock the secret of reproduction and growth—even of life itself. The discipline which concerns itself with such evidence and speculation is Genetics. Through applications to medical diseases perhaps Genetics may solve the riddle of unbridled mitosis which we call cancer. Therefore, it behooves a medical practitioner to apprise himself of these principles; reading this book is time well spent.

The first chapter covers the history of human genetics from Regnier de Graaf, who recognized that conception consisted in the union of sperm and egg, through Gregor Mendel, who first elucidated the concept of recessive and dominant inheritance, to the final determination that man has 46 chromosomes, made as recently as 1956.

Then multifactorial inheritance of such diseases as diabetes, hypertension and schizophrenia is explained. Chapter XI, entitled "Genetics and the Physician" is written for those of us who must counsel patients in these matters. A good glossary is included at the end.

I enjoyed this volume because it contains basic ideas which may underlie medical progress. When Watson and Crick showed that DNA was a helix in shape, the door was opened to understanding the mechanics of growth. Molecular biology, in short, is where it is today. Life as a principle may only be defined philosophically but the *means* of perpetuating living tissue would seem to be a key-and-lock type of puzzle. The distinction is subtle but definite and this understanding alone is worth the price of the book and the effort to read it.

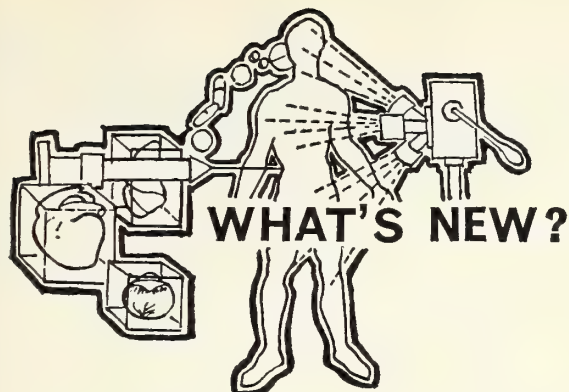
RODNEY A. MANNION, M.D.
LaPorte

THE AMA BOOK OF SKIN AND HAIR CARE

Linda Allen Schoen, editor, J. B. Lippincott Co., Philadelphia, 1976.

The AMA Book of Skin and Hair Care, produced under the authoritative aegis of the AMA by J. B. Lippincott Co., starts with the highest credentials possible. Edited by Linda Allen Schoen, research associate of the Committee on Cutaneous Health and Cosmetics, AMA, the book was prepared in consultation with members of the committee. Beamed at the laity, the book covers the practical aspects of cosmetics, care of hair and care of skin. The book is presented in a question/answer format, with the questions being those frequently asked by patients. The writing style is such that the average individual will have no difficulty in understanding it. The book can be heartily recommended both for patients and physicians. It is \$8.95 with a cloth binding, and \$4.95 for paperback.

W. D. SNIVELY, JR., M.D.
Evansville



Parke Davis announces the introduction of Ergostat Sublingual Tablets (ergotamine tartrate), a sublingual dosage form for treating vascular (migraine and cluster) headaches. The tablets contain 2 mg of the drug and are sealed in a foil pouch. They have a mint flavor and are convenient to use.

* * *

Stuart Pharmaceuticals announces Hibiclens® (chlorhexidine gluconate), a new antimicrobial skin cleanser useful against a wide range of organisms. It is approved by the FDA for marketing as a surgical scrub, hand wash and wound cleanser. It is non-toxic and non-irritating and has a persistent effect which is virtually unimpaired in presence of blood or pus. It is not related chemically to any other antimicrobial products available in the U.S.

* * *

Litton Medical Electronics has a new compact single-channel electrocardiograph. Designated the Litton Simpliscriptor EK 31, it may be operated from electrical outlets or its own batteries. Weighs only 12 pounds including batteries.

* * *

There is a new ultra-lightweight Meddev surgical headlight with a belt-borne battery pack. The reflector produces high brilliance at the focus due to computer-positioned miniature mirrors. Side cutouts in the reflector permit binocular vision. Battery life is more than 40 hours. Low wattage produces a cool light.

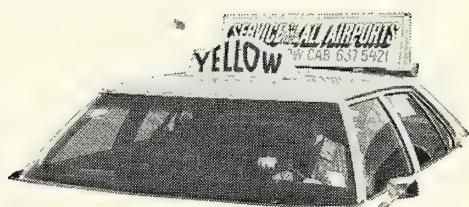
* * *

Johnson & Johnson's Health Care Division has a great idea. An educational kit to aid children, ages 6 to 9, in learning first aid. The "First Aid for Little People" contains a simple language, illustrated, first-aid booklet together with 1 cartoon filmstrip, 1 cassette, 30 student booklets, 1 instructor's folder, 4 spirit masters and 30 student award patches, all for \$8.50. One examination copy of the First Aid for Little People booklet is available free. Booklets in lots of 30 are \$1.50. Write: Instructional Materials Laboratories, 200 Madison Ave., New York City 10016.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

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THE 1976 ROSTER OF MEMBERS

For convenience in handling and reasons of economy, this year's Roster was published as a Supplement to the June issue and was printed from information carried on our computerized Master File.

Additional copies of the Roster may be ordered at a cost of \$5.00. Copies of the June Yearbook are available at \$3.00. Please send check with order.

COMMERCIAL ANNOUNCEMENTS

PHYSICIAN'S ASSISTANT student is seeking a future position in a primary care or surgery practice in Indiana. Prefers to work with a group practice, but would consider a private practice. Available for preceptorship from June 1 to Aug. 31, 1977, and/or for employment after graduation Aug. 31, 1977. Contact: Steven M. Trimble, 410 Columbia Dr., Apt. 2, Columbia City, Ind. 46725.

PHYSICIAN OPENING IN INDIANA REHABILITATION SERVICES
INDIANA REHABILITATION SERVICES has openings for physicians in its various divisions. Interested persons should contact Dr. Walter E. Deacon, #1016 Illinois Building, 17 West Market Street, Indianapolis, Indiana, Telephone: 317-633-5961.

FAMILY PRACTITIONERS, OB-GYN, AND GENERAL INTERNISTS: Health Central, a new prepaid group practice, seeks progressive physicians eager to assist with the development of an innovative health care delivery system. Must be committed to preventive care and physician group practice. Should have a strong interest in working closely with other health care professionals and consumers. Salary range \$35,000-\$45,000, with excellent fringe benefits. University town with medical schools. Located in state capital; community of 250,000 served by four hospitals. Contact Robert Chesky, M.D., Medical Director, Health Central, 3401 East Saginaw, Suite 109, Lansing, MI 48912. An equal opportunity employer.

WANTED-PSYCHIATRIST to direct the Mental Hygiene Clinic at VA Outpatient Clinic in Evansville, IN. Beginning salary up to \$45,000 depending on qualifications. 30 days vacation, 15 days sick leave, educational opportunities and many benefits. Licensed in any State. An Equal Employment Opportunity employer. Contact Chief Medical Officer, VA Outpatient Clinic, Evansville, Indiana 47708. Telephone: (912) 423-6871.

WANT TO BUY two copies of "One Hundred Years of Indiana Medicine," by Drs. Combs and Kiser. Write or call THE JOURNAL, 317-925-7545.

DIRECTOR OF MEDICAL EDUCATION position available at Community Hospital of Indianapolis, Inc., Indianapolis, Ind. Responsible for senior elective program in cooperation with Indiana University Medical Center, Continuing Medical Education for the hospital's medical staff and residencies programs. Salary is open. There is opportunity for limited private practice. Interested individuals should write to Gerald Kurlander, M.D., chairman, Medical Education Search Committee, Community Hospital of Indianapolis, Inc., c/o Administration Office, 1500 N. Ritter Ave., Indianapolis 46219.

FULL TIME POSITION as Emergency Room Physician in 365-bed Hospital. \$48,000 Guaranteed Minimum. Contact Ralph D. Weller, M.D., Emergency Room Department, or Mr. Duane R. Vorseth, Associate Administrator, Lafayette Home Hospital, Inc., 2400 South St., Lafayette, IN. 47902. PHONE: 317-447-6811.

WANTED—PSYCHIATRIST to direct the Mental Hygiene Clinic at VA Outpatient Clinic in Evansville, IN. Beginning salary up to \$45,000 depending on qualifications. 30 days vacation, 15 days sick leave, educational opportunities and many benefits. Licensed in any State. An Equal Employment Opportunity employer. Contact Chief Medical Officer, VA Outpatient Clinic, Evansville, Indiana 47708. Telephone: (812) 423-6871.

PHYSICIAN'S ASSISTANT currently training at Duke University. Seeking position in Internal Medicine, Family Practice, or ER. Able to begin in May, 1977. Variety of experience in hospital medicine, ER, clinics, and mental health. Married to a medical technologist. If interested please reply to: Randall Stevens, 1315 Morreene Road, Apt. 12-A, Durham, N.C. 22705.

CONFERENCES for Medical Professionals—A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialties included. Send a \$10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

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NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

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Established by the Indiana State Medical Association for educational and scientific purposes, including an endowment fund for publication of **The Journal**.

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The Foundation is an ideal recipient of gifts made in memory of deceased friends and relatives. A special Memorial Book is maintained to record such gifts. Special memorial funds may be established within the Foundation to honor individuals.

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March 1977
Vol. 70 - No. 3
Indianapolis



The JOURNAL

OF THE INDIANA STATE
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A character all its own.

Valium (diazepam) is a benzodiazepine with a character all its own.

Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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MEDICAL MUSEUM NOTES



Dr. Walter Bruetsch, last teacher in the Old Pathology Building, died Jan. 31, 1977, at a retirement home in Santa Barbara, California. He was 80.

Born in Germany Nov. 25, 1896, he became an American citizen in 1930. Dr. Bruetsch described his early years in Heidelberg as happy years. This time was a golden era of German science, and Germany was the mecca for American physicians seeking postgraduate training in neurology, psychiatry and neuropathology. Dr. Emil Kraepelin, noted internationally for his psychiatric descriptions and classification, was a neighbor of the Bruetsch family. Dr. Franz Nissl, noted neuropathologist, was another neighbor. Dr. Wilhelm Erb, Germany's greatest neurologist, was also a contemporary in Heidelberg, at the zenith of his career, when Dr. Bruetsch was a boy.

As a young man Dr. Bruetsch attended the Gymnasium in Heidelberg, where he developed a love for Greek and Latin which lasted throughout his life. His doctorate thesis was submitted in Latin, and even in the years before his retirement Latin texts would be stacked among the numerous volumes on his reading table.

Dr. Bruetsch was 17 years old at the outbreak of World War I. He became a lieutenant in the German infantry and was wounded in the Battle of the Somme by an explod-

ing shell, which caused a spinal cord injury producing paralysis of his legs. He was captured by the French and evacuated to the rear, where he came under the care of the great French neurologist, Joseph Babinski (who first described the Babinski reflex in the year of Dr. Bruetsch's birth). The clinical problem posed by Dr. Bruetsch's injury was whether surgical decompression was necessary, or whether watchful waiting would be more prudent. Babinski chose the latter course, and in due time Dr. Bruetsch regained his ability to walk. He was later evacuated to Switzerland in a prisoner exchange and was a noncombatant for the remainder of the war. He began his preparatory study for medicine at Davos, Switzerland, where one of his classmates was the nephew of the ill-fated Czar Nicholas II of Russia. After the War, Dr. Bruetsch studied medicine at Heidelberg and at Freiburg, receiving his MD degree in 1922.

Dr. Bruetsch came to America in 1924 and in 1925 became a member of the staff of Central State Hospital, where he introduced the malarial treatment of syphilis to America. Central nervous system syphilis was

the principal cause of commitment to insane asylums at that time. Dr. Julius Wagner von Jauregg, an Austrian physician, had noted that CNS syphilis sometimes appeared to improve when the patient had an intercurrent infectious disease. In 1917 he injected blood from a wounded soldier with malaria into a paretic patient and noted a remarkable improvement. He continued with this clinical approach, for which he received the Nobel Prize in Medicine in 1927.

In addition to introducing von Jauregg's method, Dr. Bruetsch also conducted investigations to determine the pathophysiological mechanisms involved.

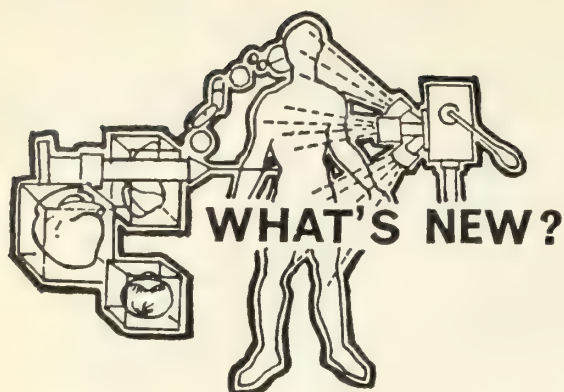
Dr. Bruetsch became internationally known for this work, and as a result was listed in *Who's Who*, and was appointed a special consultant to the United States Public Health Service.

Students in the amphitheater where Dr. Bruetsch taught (i.e., I. U. graduates from 1925 to 1955) will recall the lectures of this dedicated teacher and researcher.

CHARLES A. BONSETT, M.D.
6133 E. 54th Place
Indianapolis 46226



"THE SCIENTIST,"
painting of Dr. Walter
Bruetsch by Ruth
Bobbs, circa 1930.



Searle announces a new unit-of-use package for Flagyl®. A complete seven-day regimen for trichomoniasis consisting of twenty-one 250-mg tablets is included in the new "21" Patient Pack. Each tablet is enclosed in its own child-resistant blister, and is individually numbered for better patient compliance.

Lippincott has a new book "The Diabetic's Sports and Exercise Book." Based on the proposition that better health is only a bike ride away for most diabetics, the book stresses that diet, medication and exercise are the three main elements of diabetes control. It is filled with good advice and many references to professional athletes who are diabetic. Hardcover, \$10.95—paperback, \$5.95.

Litton has a new 3-channel electrocardiograph called the MULTISCRIPTOR EK 33, with models for 220 V or 115 V current, or 12 V from 2 rechargeable 6 V batteries. Its weight is 17.9 lbs., may be used in office or on house calls. Records three tracings simultaneously, with six programs which are selected by one switch. It is in safety class II, with floating input in all three channels.

Flowtron Aire describes a system for the prevention of deep vein thrombosis in the legs and for the reduction of leg edema. The device consists of leggings which can be inflated. Gently alternating pressure aids in emptying the venous sinusoids in muscles and reduces edema.

The ALZA Corporation has approval of the Mexican government to sell in Mexico a two-year Intrauterine Progesterone Contraceptive System. It consists of a small, flexible T-shaped unit which is placed in the uterus and will deliver a continuous low dose of the natural female hormone, progesterone, for contraception.

Sears publishes a Home Health Care Catalog which is available at any Sears selling unit, or may be obtained by mailing a coupon which appears in the current General Catalog. The 30-page catalog lists and illustrates a great variety of products useful in the care of the sick and injured, including many items for use in rehabilitation and in the care of the infirm.

Manoscope is introducing a new blood pressure measuring system. It features a manometer, called the Manoscope™, which has two gauge hands, one of which locks at systolic and the other at diastolic pressure. The arm cuff has a Velcro closure which is extra long and assures a secure fit.

Association Films has a new audio-visual guide for warming up the body prior to sports or other physical exercise. "How to Warm Up" is available in 35 mm color filmstrip/cassette or slide/cassette plus Teachers Guide, for sale or rental. 866 Third Avenue, New York City 10022.

Lexington Books has a new 736-page all-inclusive reference volume for the medical, health science and life insurance fields. Titled "Medical Risks," it was prepared under joint sponsorship of The Association of Life Insurance Medical Directors and The Society of Actuaries. It contains the broadest range of reference tables of comparative mortality and survival data. The data were previously scattered throughout medical literature. Price—\$27.50.

Macmillan Publishing has released "White Coat, Clenched Fist" (The Political Education of an American Physician), written by Fitzhugh Mullan, M.D., an angry young man, son and grandson of physicians, who is disappointed with medicine and catalogs all his complaints, presumably for gold or glory or both. If the book reads like the press release, it is interesting—may be factual too. Priced at \$9.95.

Elco International has a safe, economical, dependable source of extremely clean air inside an automobile. Portable, compact, lightweight and highly efficient it operates from the cigarette lighter plug. Removes ozone, pollen, cigarette smoke, bacteria, molds, spores, sulfur oxides, nitrogen oxides, hydrocarbons and other pollutants. Cartridges are available for such specific pollutants as carbon monoxide. The name is Filtraire Model 33 Air Purifier.

There is a new air bed. Huntleigh of England has one they call BUBBLE PAD which offers a type of alternating pressure to give bedridden patients greater relief from bed sores. The air cells are diamond shaped and larger than those in conventional mattresses. This allows a greater height difference between inflated and deflated cells than can be accomplished by the ordinary small tubular cell construction. The changeover in the inflation/deflation cycle is completed much more gently. Handled in the U.S. by Flowtron Aire Limited.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

When **impotence** due to androgenic deficiency is driving them apart



Android®-5 Buccal
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Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: "Hormones for Improved Sexuality in the Male and Female Climacteric." *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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All articles must be typewritten, double-spaced with margins of one inch.

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Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3935 N. Meridian St., Indianapolis 46208. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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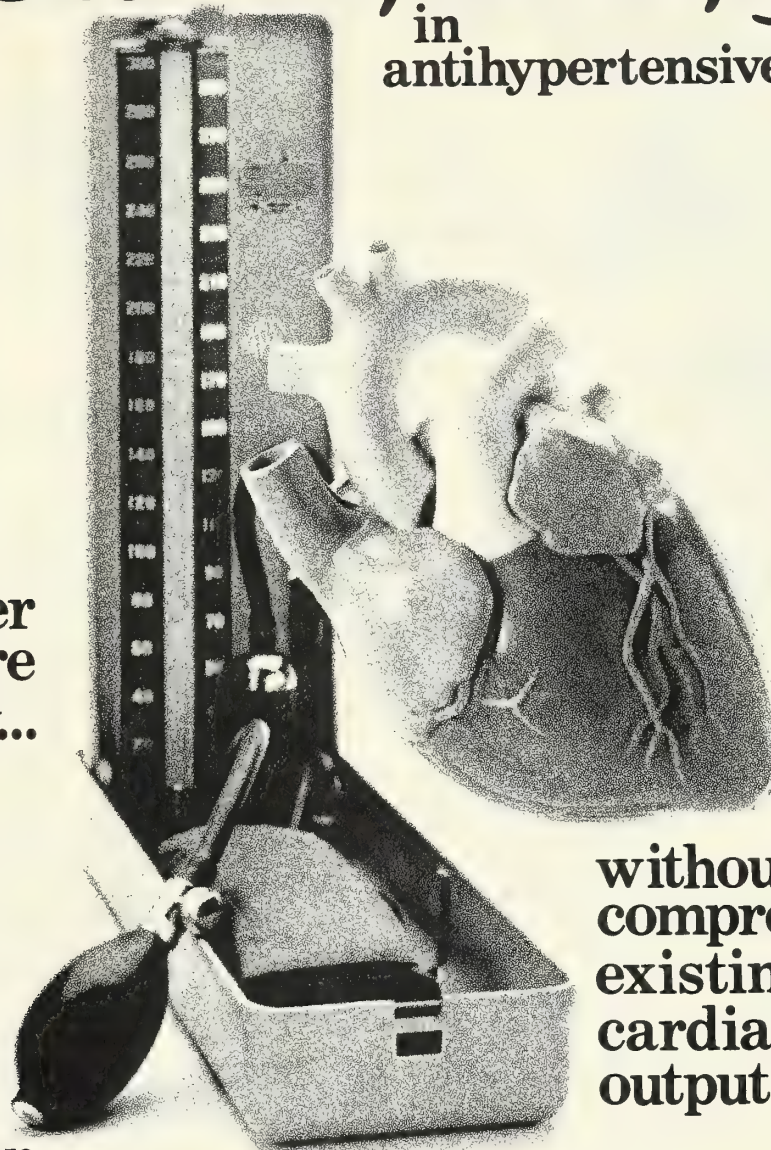
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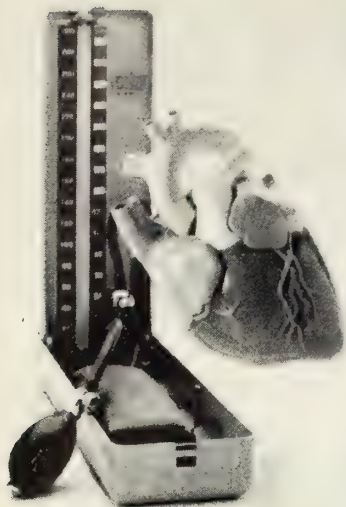
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Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

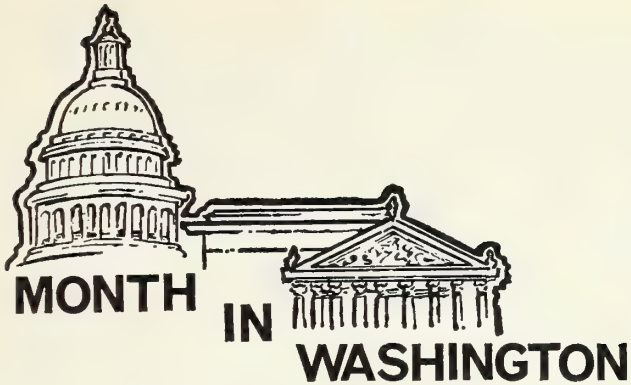
Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (707)

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This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

FOUR KEY LAWMAKERS, representing both political parties, have introduced into the new Congress an American Medical Association proposal for national health insurance.

Association President Richard E. Palmer, M.D. urged the 95th Congress and the Carter Administration to consider carefully "this forthright approach to national health insurance. This bill would extend health insurance to every American at a cost the nation could afford. It is a viable solution to the problem of providing quality health and medical care to everyone."

The Comprehensive Health Care Insurance Act of 1977 was introduced into the Senate by Senator Clifford P. Hansen (R-Wyo.) and in the House by Representatives Tim Lee Carter (R-Ky.), John M. Murphy (D-N.Y.), and John J. Duncan (R-Tenn.).

The medical profession's NHI plan would build on the structure of the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage, with the employer picking up at least 65% of the cost. Employees would not be compelled to participate.

The self-employed as well as the non-employed could purchase qualified private health insurance, through pools if needed, at a cost not more than 125% of the cost of group plans. They would have all or part of the premium paid for by the federal government, depending upon their income tax liability.

Small businesses that found the mandated plan an added financial burden would receive federal assistance.

Medicare beneficiaries could purchase supplemental insurance to bring Medicare benefits to a par with those offered elsewhere, with the government assisting people with limited resources. Medicaid would, for the most part, be supplanted under the program.

After a certain level of co-insurance was reached, depending upon income, insurance would cover all remaining expenses as a complete protection against catastrophic costs.

The co-insurance factor would deprive no one of needed care, the sponsors said. The absolute maximum that any individual would have to pay would be \$1,500; the absolute maximum for any family would be \$2,000 in any given year.

Rep. Duncan, a member of the House Ways and Means Committee, questioning how Congress could write a national health insurance plan while preserving at the same time the fiscal integrity of the Treasury, said in prepared remarks:

"The Comprehensive Health Care Insurance Act of 1977 . . . controls costs by limiting federal help to those in need by

Continued

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determining that level of need from income tax liability. Additional cost controls are found in its co-insurance factor, except for the poor; its provision of preventive care; and its promotion of competition among health insurance carriers."

THE CARTER ADMINISTRATION has announced through its new Secretary of Health, Education, and Welfare that a "well-thought through" national health insurance proposal cannot be submitted to the Congress this year.

Joseph Califano, at his first press conference after confirmation as HEW Secretary, predicted that the Administration would first concentrate on health care cost controls and better utilization of existing federal programs.

"Quite frankly," he said, "I'm not sure that we know enough about the larger problems to move faster." In addition, he said, there are other more pressing problems, such as reorganization, energy, welfare reform and unemployment, that will occupy much of the Administration and Congress' time.

Califano added that most of the policy-making officials at HEW under the Ford Administration are being replaced. This is what the American people expect of a new administration, he added.

Asked about reorganization of the HEW Department and the campaign proposal to make education a cabinet department, Califano predicted there would be no major reorganization proposal for his department that would be ready for submission to Congress this year.

Asked whether groups such as the American Medical Association and the Pharmaceutical Manufacturers Association, groups with interest in the Medicaid side of welfare, would be consulted, Califano said they will be consulted as well as

all other groups involved in welfare programs.

Califano took a couple of swipes at the former HEW Administration, saying he found a "substantial entourage" of 143 officials at the level of the secretary's office. He said he plans to cut this substantially and transfer these functions to the responsible agencies, at a savings of more than \$500,000.

MEDICARE AND MEDICAID SPENDING next fiscal year is predicted to top \$35 billion, up more than \$5 billion for the estimate of the current fiscal year. The Ford Administration's final, and somewhat academic, budget proposal to Congress for financing the federal government next fiscal year set overall health, education and welfare spending in fiscal 1978 at \$159 billion, an increase of \$11 billion. More than \$100 billion of this, however, is in Social Security trust fund outlays.

There was little new in the budget plans for health compared with last year's budget, except for the steady creep upward (19%) of costs for Medicare and Medicaid. Budget requests for most HEW health activities were kept to about this year's level. The Carter Administration is slated to submit its own federal spending plans about mid-February. These are certain to include hefty proposed boosts in some health areas.

HEW spending on health has jumped from \$9.7 billion in 1968 to a predicted \$42.2 billion. It will rise another \$3 billion next year, according to budget charts.

TIGHTENING MEDICARE-MEDICAID FRAUD PROVISIONS is one of the first orders of business before Congress. Legislation has been introduced in House and Senate by key health lawmakers who pledged speedy action.

The bill, sponsored by Sen. Herman Talmadge (D-Ga.) and Reps. Paul Rogers (D-Fla.) and Dan Rostenkowski (D-Ill.), makes provider fraud a felony rather than a misdemeanor, arms Professional Standards Review Organizations (PSROs) with power to review "Medicaid Mills," requires certain financial disclosures by nonphysician providers, and requires PSROs to turn over information to state and federal agencies investigating fraud and abuse as well as health planning agencies.

Rep. Dan Rostenkowski (D-Ill.), chairman of the House Ways and Means Subcommittee on Health, said in a House floor speech that "strong efforts must now be made both legislatively and administratively through a renewed commitment to interdepartmental cooperation to bring a sense of mortality back into our federal health payment programs."

Rep. Paul Rogers (D-Fla.), chairman of the House Commerce Subcommittee on Health, said the honest, hard-working provider suffers from instances of fraud and abuse because his reputation is damaged. "We have an obligation to all concerned to improve the administration and management of our medical care programs."

Joint hearings will be held shortly by the two subcommittees on the legislation.

The measure was considered by Congress during the last session but time ran out before action could be taken.

More sweeping changes in Medicare and Medicaid, including changes in reimbursement methods, are expected to be considered later.

THE SUPREME COURT HAS REFUSED to review a 1975 Florida law designed to substitute mediation for professional liability litigation. Left standing was a decision last May by the Florida Supreme Court which upheld the state's Medical Malpractice Reform Act. The law makes it mandatory for a complainant to submit to mediation before filing a lawsuit. The three-member mediation panel is composed of a circuit judge, who is the referee, plus a physician and a lawyer. The panel's conclusion as to liability may be admitted as evidence at a later trial.

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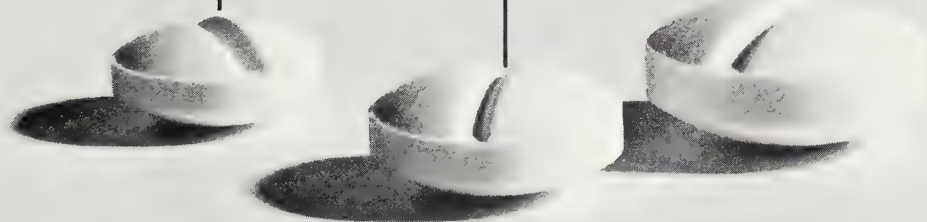
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***INDICATIONS.** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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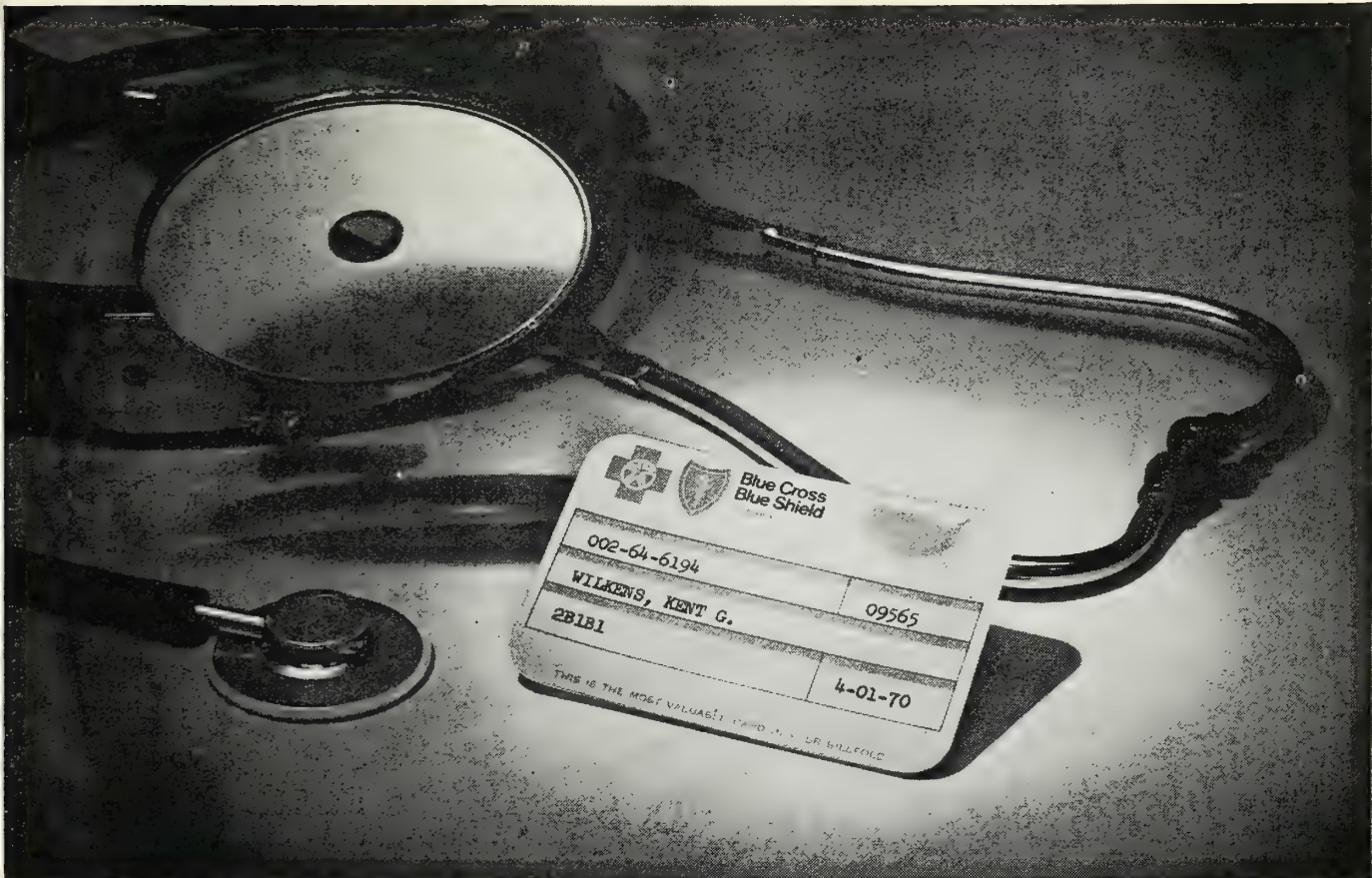
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The Swan-Ganz catheter has become an important tool for measuring bedside hemodynamics. The catheter can be introduced by a number of methods. A percutaneous method through the basilic vein is described. Hemostasis is easily assured. This method is useful even in the heparinized patient.

A Practical Method of Percutaneous Introduction of Swan-Ganz Catheters

S. S. MOORTHY, M.D.
V. K. STOELTING, M.D.
Indianapolis

THE balloon tipped floating catheter used to measure hemodynamic parameters at the bedside was first introduced by H. J. C. Swan, W. Ganz, and others.¹ These floating catheters with a thermistor probe made measurement of cardiac output by the thermodilution technique an easy method.² The catheters can be introduced by a cutdown of a peripheral vein in the cubital fossa or percutaneously through a peripheral or a central vein.

The following description presents a simple and practical method of introducing the thermistor probe, 7-F Swan-Ganz catheter percutaneously.

Necessary Materials

1. A 10 ml syringe with a 25 gauge needle containing 5 ml of 1% lidocaine.
2. A standard 20 gauge arteriovenous needle with flanges and hub. This can be attached to a

syringe. (Cook Incorporated).

3. Desilets-Hoffman catheter exchange set with teflon sheath (8F size) (Cook Incorporated). (Fig. 1)

4. Sterile drapes, venesection set and sterile gloves.

5. Swan-Ganz catheter with two 3-way stopcocks and 1 ml tuberculin syringe attached to proximal ends.

Method

Prepare the cubital fossa: Strict asepsis is observed for this procedure. The area is cleaned with an antiseptic solution followed by 80% propyl alcohol and draped. Careful hand washing and the use of sterile gown and gloves by the operator is essential.

Selection of a good vein: The veins in the cubital fossa are made prominent by applying a tourniquet to the upper arm. If the veins are not prominent, warm drapes are applied to the arm for 10 to 15 minutes before preparing the area. The best results are obtained by selecting the basilic vein. The smaller

tributaries, cephalic or median cubital veins, usually have valves which cannot be easily bypassed.



FIGURE 1

Shows the arteriovenous needle and the Desilets-Hoffman catheter exchange set with guide-wire, teflon catheter and teflon sheath.

From the Department of Anesthesiology, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

The standard arterial-venous needle is attached to a 10 ml syringe and introduced into the basilic vein. When blood can be freely aspirated, the syringe is detached and the guide wire from the catheter exchange set is introduced into the vein. The guide wire should move freely within the lumen of the vein. The arterial-venous needle is withdrawn leaving the guide wire in place. A nick is made in the skin and subcutaneous tissues with a scalpel at the cutaneous entrance of the guide wire. The teflon catheter is now introduced into the vein without the teflon sheath. Once the catheter is within the vein, it is withdrawn and re-introduced now with the teflon sheath. When the catheter and the sheath are in the lumen of the vein, the guide wire and the catheter are withdrawn, leaving the sheath in the vein. If the teflon sheath is properly placed within the vein's lumen, a free flow of blood is seen. The tourniquet is now released.

After testing its balloon, the Swan-Ganz catheter is introduced through the sheath with the concavity of the curve at the end of the catheter directed medially. When the catheter has been introduced to the 40 cm mark, (the tip is now in the thorax), the balloon is inflated

and the catheter is advanced. The proximal ends are attached to a continuous flush apparatus ("Intra-flow"). The proximal end of the catheter's "pulmonary artery" lumen is attached through a 3-way stopcock to a pressure monitor calibrated to the venous pressure system and displayed on the oscilloscope. As the catheter passes the right atrium, the right ventricle and the pulmonary artery, typical pressure waves are seen. (Fig. 2) When the pulmonary artery has been entered, the catheter is stabilized and the teflon sheath is withdrawn from the vein over the catheter. The balloon is deflated. The proximal atrial lumen is attached to a 3-way stopcock. The proximal ends are secured on small wooden tongue blades with adhesive tape to prevent bending or breaking. Continuous flushing is provided to maintain these lumens patent.

The catheter is now secured at the entry into the vein in the cubital fossa by a single suture incorporating the vein, the catheter and the overlying skin. If there is bleeding from the distal part of the vein, hemostasis is secured by a suture placed at this point. The exterior portion of the catheter is wrapped in a sterile towel and secured to the forearm. The site of entry of the

catheter is covered with an antibiotic ointment and dressed.

The position of the tip of the catheter is checked by an x-ray of the chest. The catheter can be withdrawn or advanced as required. The tip of the catheter is routinely maintained in a main pulmonary artery (Fig. 3). Wedge pressures can be obtained with inflation of the balloon. With deflation, the catheter retracts to the main pulmonary artery.

Comment

We are introducing the balloon tipped catheters in the operating room primarily in cardiac patients undergoing open heart surgery. Introduction of the catheters is being done percutaneously and introduction through the internal jugular vein⁴ and subclavian vein⁵ has been described. The method we use has the advantage of complete hemostasis, particularly in the heparinized patients.

Selection of a good vein in the cubital fossa is the most important step for the successful introduction of the catheter. Passing the catheter through the basilic vein gives the highest rate of success.

The use of the catheters is not a benign procedure. A number of complications have been described.⁶ Proper precautions should be taken during the floating and maintenance of the catheters and, if necessary, appropriate corrective measures should be taken.

Summary

The Swan-Ganz catheter has become an important tool for measuring bedside hemodynamics. The catheter can be introduced by a number of methods. We describe a percutaneous method through the basilic vein. Hemostasis is easily assured. The method is useful even in the heparinized patient.

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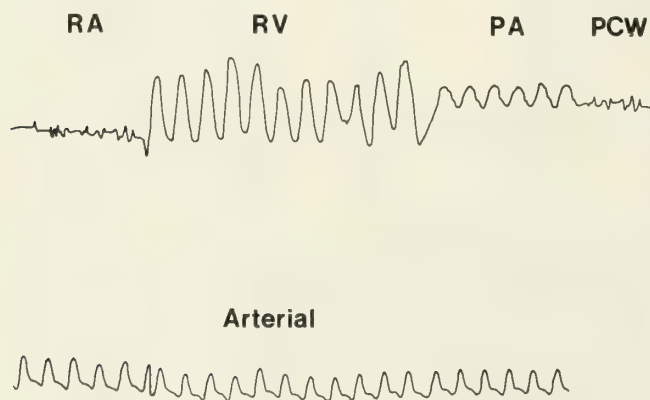


FIGURE 2

Shows the typical pressure wave patterns as the catheter is advanced (upper panel).

RA = Right Atrium; RV = Right Ventricle; PA = Pulmonary Artery; PCW = Pulmonary Artery Wedge Pressure.

The lower panel shows arterial pressure wave. EKG is not shown.

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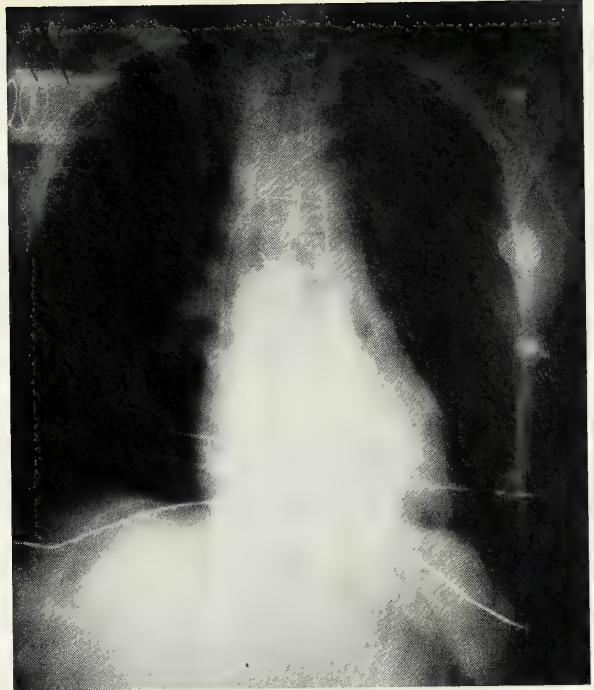
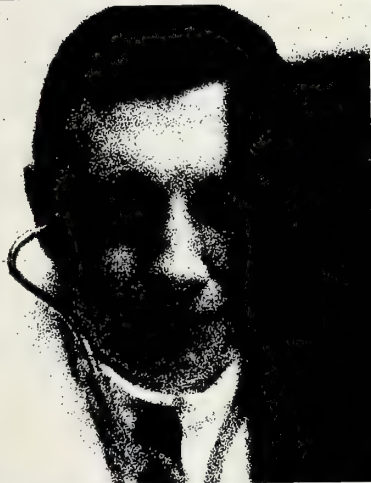


FIGURE 3
Position of the tip of the Swan-Ganz catheter is verified by x-ray of the chest. It is in the right main pulmonary artery.



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Predicting the Complications of Myocardial Infarction

R. JOE NOBLE, M.D.

Indianapolis

SINCE the advent of the coronary care unit, the mortality of patients admitted to the hospital with acute myocardial infarction has been reduced. Whereas in the past nearly a third of the patients admitted to the hospital with this diagnosis succumbed, at present approximately 85% of such patients are expected to survive the acute episode. This impressive reduction in mortality has been accomplished by the prevention or the rapid recognition and termination of ventricular fibrillation.

As a result of the considerable amount of information learned from the coronary care unit experience,

the medical and nursing care of the patient with acute myocardial infarction has progressed into a new dimension. It is now possible to predict many complications of acute myocardial infarction in addition to the ventricular arrhythmias; and, having predicted these possible complications, efforts can be directed toward preventing them, or, failing that, rapidly recognizing and managing the complications as they arise.

Intense investigation is currently under way toward defining means of minimizing the size of the infarction, or protecting the jeopardized myocardium adjacent to the already infarcted zone. It is hoped that these investigations will usher in a still newer dimension in coronary care, but this concept is not the subject of the present presentation. Instead, we are concerned with attempting to predict possible complications for a specific myocardial infarction.

Such a prediction requires three steps, each of which is closely tied to a knowledge of the anatomy and distribution of the coronary circulation. First of all, the physician must localize the myocardial infarction on the electrocardiogram. Second, having done that, consider which coronary artery is responsible for that specific myocardial infarction. Finally, in order to extrapolate to the clinical situation, consider which

vital cardiac structures are supplied by that same coronary artery. Then one is in a position to predict which complications may develop.

To localize the myocardial infarction on the electrocardiogram, consider Figure 1, which exhibits a frontal view of the heart superimposed upon the Einthoven triangle, in order to point out the electrocardiographic leads which record the electrical potentials characteristic of infarction. Consider first the right coronary artery, which is inter-

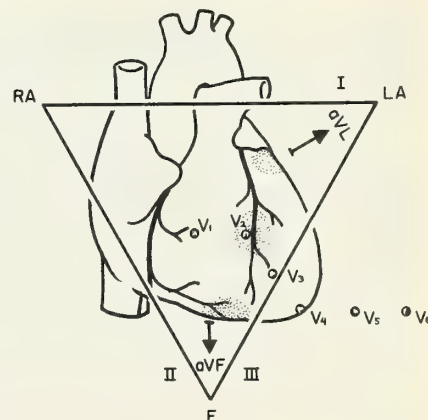


FIGURE 1

The electrocardiographic localization of myocardial infarction. Leads 2, 3, and aVF overlie the inferior surface of the heart, which is supplied by the right coronary artery (on the left); the precordial leads overlie the region supplied by the left anterior descending coronary artery; leads 1 and aVL also record this region, plus the high lateral wall supplied by the left circumflex coronary artery (upper right).

From the Krannert Institute of Cardiology, the Department of Medicine, Indiana University School of Medicine, and the Veterans Administration Hospital, Indianapolis.

Send reprint requests to Dr. Noble at Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis, 46202.

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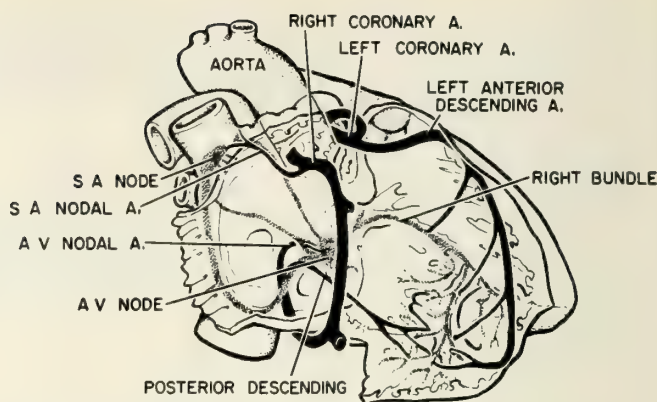
Dr. Noble is a teaching scholar of the American Heart Association.

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posed between the right atrium and the right ventricle in the atrio-ventricular (AV) groove before descending as the posterior descending coronary artery to supply the posterior and inferior surfaces of the heart. Thus, an occlusion of the right coronary artery generally results in an inferior wall myocardial infarction which is displayed electrocardiographically by the typical ST segment changes and Q-waves in the inferior leads 2, 3, and aVF. On the other hand, following occlusion of the left anterior descending coronary artery, which descends in the anterior interventricular groove, the result is an anterior myocardial infarction, which is generally displayed electrocardiographically in the anterior precordial leads overlying that area of infarction. A high lateral infarction, which may result from occlusion of the left circumflex coronary artery, would be indicated in the leads reflecting the electrical activity of the high lateral surface: leads 1 and aVL. For clinical purposes, all the clinician is really interested in is differentiating between an inferior and an anterior wall myocardial infarction, which he can do quite accurately.

Having done that, what other

FIGURE 2
Right sagittal view of heart, conducting system and coronary arteries. See text.



vital cardiac structures are supplied by those same arteries? With that information, the physician can predict complications. Here I'd like to dichotomize our conversation. First of all, let's consider the arrhythmias, and then we'll concentrate on the "pump"—i.e., the muscle mass that is supplied by the various coronary arteries.

Bradycardias

We'll begin by trying to predict which bradycardia will develop in a specific patient with an acute myocardial infarction. To do that, look at Figure 2: a sagittal view of

the heart as viewed from the right side of the heart. The free wall of the right ventricle and the right atrium have been stripped away, so as to provide a view of the right ventricular septum and the right atrial septum. Superimposed we see the conducting system in stippled lines. Note the sinus node (SA node) and the AV node. The latter progresses to the bundle of His which then divides into the right bundle on this side of the septum, the left bundle penetrating across to the other side of the septum. The coronary arteries are also diagrammed.

Consider first the right coronary artery. The right coronary artery arises from the right sinus of Valsalva to course through the right atrioventricular groove to the back of the heart, where at the crux of the heart it turns to descend to the posterior and inferior surfaces of the heart, supplying those areas. So, occlusion of the right coronary artery results in an inferior wall myocardial infarction. In the majority of hearts the right coronary artery also sends a branch near its origin to the sinus node, called the SA nodal artery. Consequently, the clinician may predict that a patient with an inferior wall infarction due to occlusion of the right coronary artery may very likely demonstrate some malfunction of the sinus node. Indeed, when a patient with an inferior myocardial infarction is seen early enough (for example, in a mobile coronary care unit or within the first few hours of the development of chest pain), the majority of

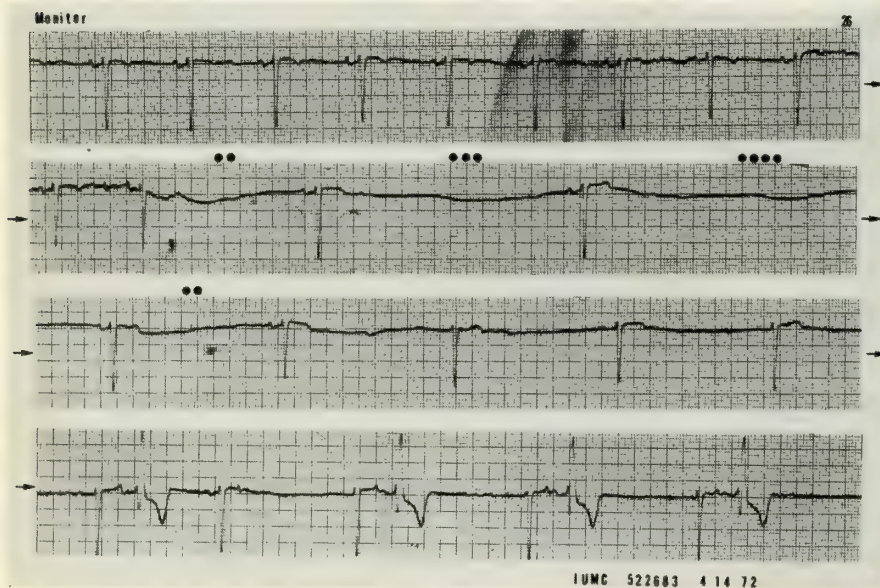


FIGURE 3

SA node exit block. Note the pauses to be exact multiples (2, 3 or 4) of the sinus interval. Presumably, the sinus node did discharge, but the impulse was prevented from exiting from the SA node to reach and depolarize the atria. Consequently, there is no p-wave. And, since the atria were never excited, neither were the ventricles.

those patients will have sinus bradycardia.

There are other kinds of atrial braycardias—for example, sinus arrest when the sinus node just ceases functioning altogether. A third example would be sinus exit block, of which Figure 3 is an example. Sinus exit block is characterized by sinus rhythm (on the top strip) with periodic pauses which are exact multiples of the sinus rate. For example, the pause identified by two dots is exactly two of the sinus intervals; the pause identified by three dots is exactly three of the sinus intervals, suggesting that the sinus node did depolarize precisely on time, but that the impulse was prevented from exiting from the sinus node to excite the atrium. These three varieties of atrial bradycardia—sinus bradycardia, sinus exit block, or sinus arrest—are not uncommon in the setting of acute inferior wall myocardial infarction. Knowing the distribution of the right coronary artery, the physician is not surprised that any occur in a patient with that localization of infarction.

Now follow the right coronary artery downstream to the crux of the heart, where in the majority of hearts this artery provides a branch called the AV nodal artery to supply the AV node. Again, the clinician can predict and is not surprised by the fact that a patient with an inferior wall infarction may develop conduction block at the level of the AV junction.

Block at this level, which has been termed Type I block, may develop in one of three degrees: first degree, second degree or third degree. First degree block simply means that every atrial impulse conducts through the AV node but does so slowly. Consequently, the PR interval is prolonged. Second degree block means that some of the atrial depolarizations conduct through the AV junction to the ventricle and some don't. Third degree block means that none of the supraventricular impulses traverse the AV junction to excite the ventricle. If the block is Type I at the level of the AV junction, whether first or second degree, the impulse does

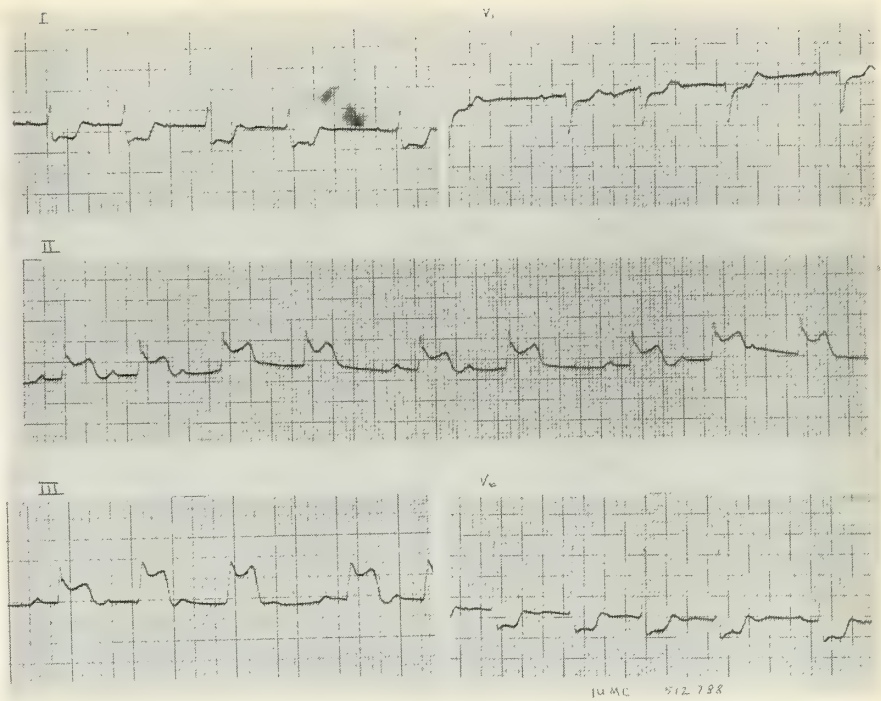


FIGURE 4
Wenckebach second degree, Type I block, due to acute inferior wall myocardial infarction.

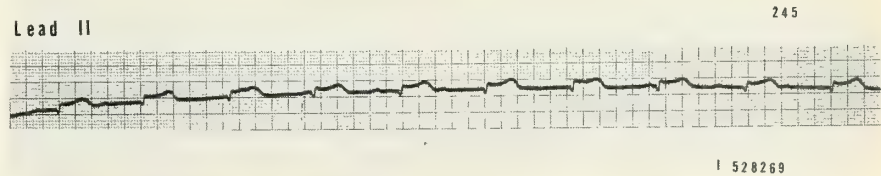


FIGURE 5
Type I heart block associated with inferior wall myocardial infarction.

conduct via the normal conducting pathway: the AV junction, the bundle of His, and the right and left bundle branches. As a result, the QRS is narrow and of normal appearance. Even if the patient develops third degree block at the level of the AV junction, the next best pacemaker of the heart will assume pacing function. This is in the vicinity of the bundle of His. It, too, will traverse the His bundle and the conducting system normally to result in a normal, narrow-appearing QRS. Usually the AV junction escapes at a quite reasonable rate of 50 or 55 per minute. Consider two examples: Figures 4 and 5.

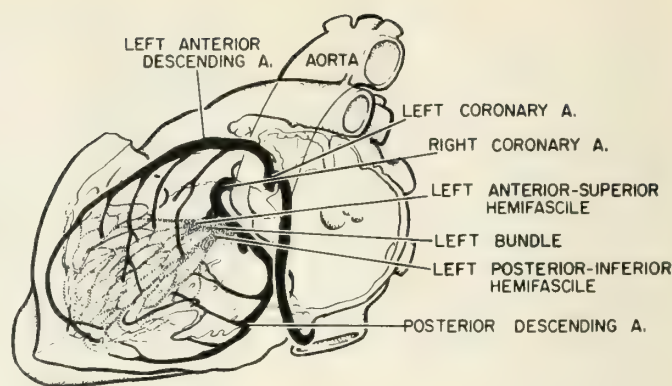
The ECG recorded in Figure 4 represents a patient with an acute inferior wall infarction. (Note ST segment elevation in leads 2 and 3,

with reciprocal ST depression in leads 1, V1 and V6.) The first P conducts to the QRS and the second P conducts with a longer PR interval; the third conducts with a still longer PR interval; the fourth P-wave, situated on the T-wave, conducts to the next QRS; but the fifth P-wave, superimposed on the ST segment, fails to conduct—it is blocked. The tracing is an example of second degree block (some of the P-waves conduct, some do not) with an acute inferior wall infarction. Specifically, this is Wenckebach second degree, Type I block at the level of the AV node. The sequence of events of gradually prolonging PR interval until conduction fails begins anew with the sixth P-wave in lead 2. In figure 5 is seen a perfectly regular QRS, which is narrow.

Regular P-waves are also seen, but at a different and more rapid rate, marching through the QRS complexes. In other words, perfectly regular P-waves and perfectly regular QRS complexes are recorded at two different rates, so this is complete dissociation between the atrium and the ventricles. Again, the ventricle is being driven by a perfectly regular, narrow QRS, suggesting that the junction has taken over the pacemaking function of the heart. This is an example of complete AV dissociation, Type I block, at the level of the AV node.

Should this arrhythmia be treated? There are only two reasons I know to treat any arrhythmia. One is that the arrhythmia may suddenly produce death—that is, asystole or ventricular fibrillation. There is no threat, in general, that a bradycardia due to acute inferior wall infarction, whether at the sinus node or the AV node, will suddenly terminate in asystole. Thus, the only reason for treating a patient with this kind of bradycardia is the second reason for treating any arrhythmia—namely, that it produces hemodynamic deterioration. And if the arrhythmia does not produce hemodynamic de-

FIGURE 6
Left sagittal view of heart, conducting system and coronary arteries.



terioration, then there is no justification for providing potentially lethal treatment to correct a situation which really isn't producing any significant risk.

Contrast that patient with another patient with bradycardia. This is a patient with occlusion of the left anterior descending coronary artery resulting in infarction of the anterior wall of the heart. As in Figure 6, turn the heart over in order to look at the left heart, having stripped away the left ventricular free wall. Look at the left ventricular septum, the left atrial septum, and again the conducting system, now down in the ventricle. The left bundle branch is

displayed diagrammatically to be divided into an anterior hemifascicle in front and a posterior-inferior hemifascicle (or half of bundle) in back. Now we're concerned with the left anterior descending coronary artery, which does not generally provide blood to the sinus node or to the AV node. Instead, if bradycardia of a high degree develops in a patient who has an occlusion of the left anterior descending coronary artery, which produces an anterior myocardial infarction, then this heart block may be due to bilateral bundle branch block. Now the block in conduction is at the level of the ventricle, at the bundle branches, as opposed to the AV node or the sinus node. And this is entirely different from bradycardia due to occlusion of the right coronary artery resulting in inferior wall infarction.

A patient with an anterior infarction who develops block may also develop first, second or third degree block. But the level of the block is different; it's now at the level of the bundle branch system, and this is called Type II block, in contrast to Type I block, which occurs at the level of the AV node. Type II block can be differentiated from Type I principally by the coexistence of a bundle branch block pattern, with a broad, abnormal appearing QRS.

Inspect precordial lead VI in Figure 7 to note a broad QRS pointing toward V1; this is a right bundle branch block. In lead 2 one sees marked left axis deviation, which would be characteristic of block of one of the hemidivisions of the left bundle branch—namely, the left anterior hemifascicle. So this would be

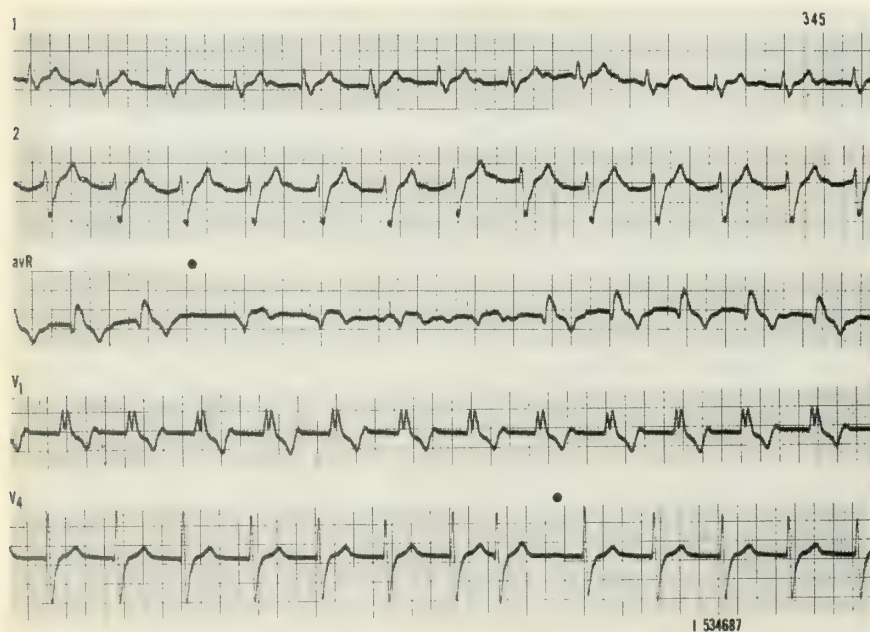


FIGURE 7

Trifascicular block: right bundle branch block, left anterior hemiblock, and first degree or second degree (lead aVR) Type II block. (The complexes in the center of lead aVR are driven by a demand pacemaker.)

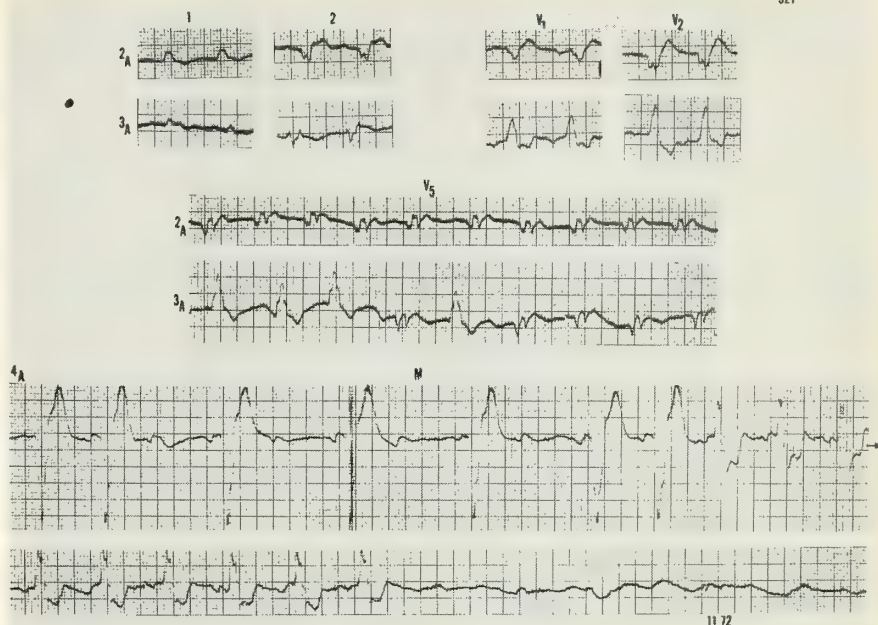


FIGURE 8

Acute anterior myocardial infarction, with alternating LBBB, RBBB and asystole due to complete heart block. The monitored leads at the bottom exhibit 2:1 block with LBBB, later RBBB and then complete block.

one. With an inferior infarction, one can predict block at the level of the AV junction which will not produce asystole. But with an anterior infarction, with block at the level of the bundles, without any real warning, the P can fail to conduct. The result would have been asystole had a pacemaker not been placed.

Consider such an example, pictured in Figure 8. This patient was admitted to the hospital at 2 o'clock

in the morning, with a history characteristic of acute infarction. The QRS is broad; look at V1: broad QRS directed away from the electrode at V1, toward the left ventricle, so it represents a left bundle branch block. The configuration of the left bundle branch block is also seen in V5. At 3 a.m. a broad QRS is still seen, but now the QRS is pointing towards V1, so it is a right bundle branch block. And if we look in V5 at 3 a.m., we now see the configuration of the right bundle branch block alternating with left bundle branch block. In other words, the patient has provided evidence that he has a conduction defect in both sides of the septum as a result of his acute anterior infarction. This was not recognized, unfortunately, but the reader can predict what's going to happen at 4 a.m.: alternating left and right bundle branch block with second degree Mobitz II block, finally terminating in complete block and asystole.

The point is that by localizing the infarction on the electrocardiogram, one can predict what kinds of bradycardia may develop. Having predicted that this complication may

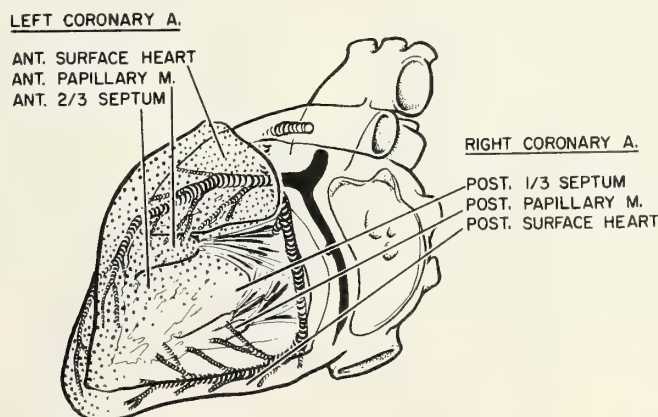


FIGURE 9

Left sagittal view of myocardium and coronary circulation.

develop, the physician will monitor for it and is prepared for it when and if it does occur.

Myocardial Failure

At this point we will shift the emphasis from the bradycardias to muscle damage. Consider Figure 9. Note that the left coronary artery supplies a huge mass of muscle, often as much as two thirds of the anterior and lateral surface of the left ventricle. So one can easily imagine why a patient with an occlusion of this vessel with an anterior infarction has heart failure. Whether it is apparent clinically or whether hemodynamic studies are required, there is some impairment of left ventricular function. Heart failure can progress to shock, which is just a worse degree of heart failure, with lower cardiac output and higher left ventricular filling pressure. Thus, the physician can predict that a patient with an extensive anterior infarction is prone to develop shock.

When shock develops, the physician should keep in mind that there are several causes of shock in the setting of acute myocardial infarction. True cardiogenic shock is shock due to a massive infarction, which would be expected with a massive anterior wall infarction, but not other kinds of myocardial infarction. When a patient develops shock, the physician considers a differential diagnosis. Could the cause, for example, be hypovolemia, such as could result from diuretics, intense diaphoresis or vomiting? Another variety of shock to consider is the bradycardia-hypotension syndrome. This is a reflex kind of hypotension which is common in a patient with an inferior wall myocardial infarction, as opposed to cardiogenic shock, which is common in a patient with an anterior wall myocardial infarction. The mechanism isn't precisely known, but it seems to be an activation of the parasympathetic and functional "denervation" of the sympathetic nervous system resulting from ischemia of the inferior wall of the heart. It is characterized by a relative brady-

cardia, despite hypotension. With hypotension one would normally expect an accelerated heart rate, but in this instance the heart rate does not exceed 100/minute. Thus, the patient has a relative bradycardia. It is important to make the differential between the bradycardia-hypotension syndrome and true cardiogenic shock, since the former patient with acute inferior infarction will probably respond very favorably to the administration of atropine. On the other hand, if the physician misdiagnosed the condition as true cardiogenic shock, he could potentiate the problem with potent vasoconstrictors, for example. Again, one can predict not only shock, but the mechanism of shock, if he has localized the infarction on the electrocardiogram before it occurs.

Consider some additional "muscle" complications of infarctions. The left anterior descending coronary artery supplies the blood supply to the anterior papillary muscle. It is not the sole supplier of this muscle, and the circumflex vessel also provides some blood. So it is uncommon for the anterior papillary muscle to become necrotic and to rupture after occlusion of the left anterior descending coronary artery. On the other hand, it is extremely common for the anterior papillary muscle to be ischemic in the setting of an anterior wall infarction. When the papillary muscle does not contract properly, then the mitral leaflets do not appose properly and mitral regurgitation results. The great majority of patients with an anterior wall infarction will exhibit a murmur of papillary muscle dysfunction, if one listens closely enough and often enough.

The anterior coronary artery also supplies the anterior two thirds of the ventricular septum. Necrosis of this area of the septum can explain why a patient, on about the fifth day of hospitalization, suddenly develops severe heart failure or shock, and at the bedside you hear a murmur along the left sternal border, usually accompanied by a thrill. You have thought in advance that this patient is certainly susceptible

to a ventricular septal perforation and it turns out that about two-thirds of these are related to anterior wall myocardial infarctions, probably because the anterior two thirds of the septum is supplied by that artery.

Let's consider the right coronary artery. This artery does not supply as much muscle as does the anterior. Overt congestive heart failure, therefore, is not expected with an inferior as with an anterior wall myocardial infarction. Shock is not expected; if it develops, think of another reason. The bradycardia-hypotension syndrome is one possibility, but there are other potential causes for shock in the patient with acute inferior wall infarction. Rupture of the posterior papillary muscle is one possibility. The posterior descending coronary artery provides the entire supply of blood to the posterior papillary muscle. Consequently, occlusion of this vessel, resulting in an inferior and posterior wall infarction, can also result in necrosis and subsequent rupture of the posterior papillary muscle. This is generally a devastating complication of acute infarction, characterized by shock and very high mortality. A murmur of mitral regurgitation may be present, but it is generally quiet or even absent, due to the profound depression in cardiac output. It is unusual for a patient suffering this complication to survive even two hours.

The right coronary artery supplies the posterior third of the ventricular septum. Consequently, ventricular septal perforation may also complicate acute inferior infarction. About one third of the reported cases of acute ventricular septal rupture have been in association with inferior wall infarction. As emphasized before, when shock develops in an individual with inferior wall infarction, the clinician immediately looks for an explanation other than massive muscle necrosis. Many of these explanations are treatable—for instance, the bradycardia-hypotension syndrome, or even ventricular septal perforation which may respond to intensive medical therapy or surgical intervention.

Ventricular Arrhythmias

Returning to rhythm disturbances, consider the ventricular tachyarrhythmias. Ventricular arrhythmias of all varieties may accompany ischemia or infarction involving any zone of the heart. These arrhythmias result from what has been termed "electrical instability" of the ischemic myocardium, for want of a better term.

However, even in the instance of ventricular arrhythmias, the clinician should evaluate the zone of infarction to determine if this localization might be contributing to the ventricular arrhythmia. For instance, a common cause of ventricular arrhythmias is heart failure. Since patients with infarction of the anterior wall of the heart are prone to heart failure, the physician is immediately alerted to the possibility that the ventricular arrhythmia which he documents on the monitor in his patient with acute anterior infarction may be due to heart failure rather than to "electrical instability." If the former, then conventional antiarrhythmic therapy will be useless, if not dangerous. The only appropriate therapy would be attempts directed toward amelioration of the heart failure, such as digitalis or diuretics.

In contrast, bradycardia may also elicit ventricular arrhythmias. This relationship results from the well known electrophysiologic phenomenon termed "the rule of bigeminy": the longer the R-R interval or the slower the heart rate, the more likely ventricular ectopy, whether premature ventricular extrasystoles or ventricular tachycardia. Since patients with infarction of the inferior wall of the heart are prone to otherwise benign bradycardia, the clinician is instantly alerted to the possibility that his patient with acute inferior infarction may be exhibiting ventricular tachycardias due to bradycardia. If so, the only appro-

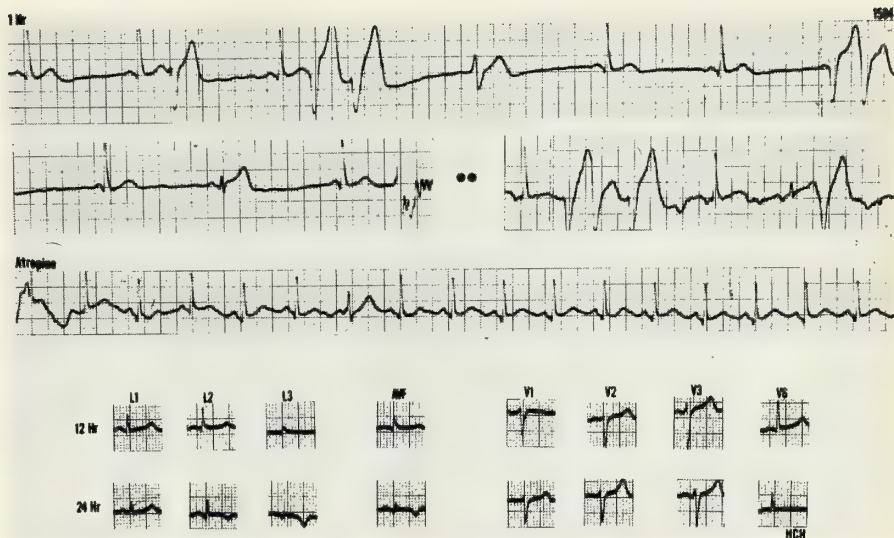


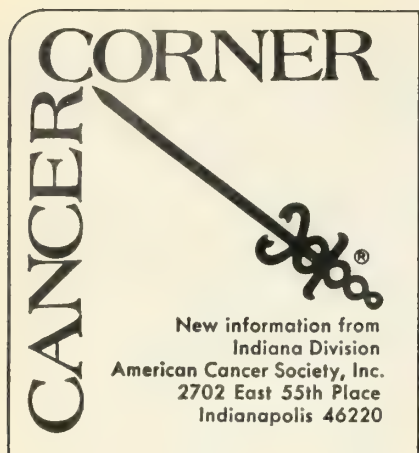
FIGURE 10

Bradycardia induced ventricular tachycardia and ventricular fibrillation. The ventricular tachyarrhythmias respond to acceleration in the heart rate. Incidentally, note that the ECG recorded on admission and still 12 hours later is normal! The patient was admitted to the coronary care unit on the basis of his history. Had he not been monitored, he would have succumbed to ventricular fibrillation at 1 hour. Not until the next day (24-hour tracing) was the acute inferior wall infarction diagnosed, though it was suspected from the history and associated supraventricular bradycardia.

priate therapy is directed toward a moderate acceleration in the intrinsic heart rate. Conventional antiarrhythmic therapy, such as lidocaine, may further depress the intrinsic heart rate and actually aggravate the ventricular arrhythmia. An example of successful therapy of ventricular arrhythmia due to the rule of bigeminy by acceleration in heart rate is provided in Figure 10. In this patient with acute inferior infarction (as demonstrated in the 12-lead serial electrocardiograms at the bottom) bradycardia is complicated by ventricular arrhythmias. At the point of the two dots ventricular defibrillation was required on two separate occasions. With an acceleration in the sinus rate induced by atropine, the ventricular arrhythmia is suppressed. In other words, the mechanism of ventricular arrhythmia was not "electrical instability" but bradycardia, according to the rule of bigeminy.

In summary, by (1) localizing the myocardial infarction on the electro-

cardiogram, (2) recognizing which coronary artery supplies that zone of the heart and (3) recognizing what other vital cardiac structures are supplied by that same coronary artery, the physician is capable of predicting the potential complications of his individual patient with acute myocardial infarction. He may predict a bradycardia and know in advance whether it will be Type I (which is generally benign) or Type II (which may require urgent prophylactic therapy). He may be able to predict heart failure or shock and, more importantly, the mechanism responsible for the shock. Obviously this capability allows the physician to monitor for potential complications, to recognize them immediately at their onset, and to select appropriate therapy when they do develop. It is hoped that such an approach to patients in the coronary care unit will even further reduce morbidity and mortality of acute myocardial infarction. ◀



**Third Annual Cancer Symposium
for the Primary Care Physician
June 3-5, 1977**

Marriott Inn, Clarksville

Co-sponsored by the Indiana Division of the American Cancer Society and the Department of Medical Education at Methodist Hospital of Indiana, Inc., Indianapolis. Mark your calendar — details will be published in the April issue of *The Journal*.

From: Lawrence H. Einhorn, M.D.
Department of Hematology-On-
cology,
Indiana University Medical Cen-
ter
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We are currently conducting extensive studies in all stages of Hodgkin's disease and would be most appreciative of any referral of patients with active Hodgkin's disease. We are especially interested in any patient who has failed to achieve a complete remission on MOPP for investigational chemotherapy with a new combination regimen, or any patient with Stage III or IV disease, or newly diagnosed Hodgkin's disease, for consideration of combined chemotherapy-radiotherapy protocols.

**Cigarette Smoking Among
Teen-Agers and Young Women**
(Excerpts from a report published by the National Cancer Institute in cooperation with the American Cancer Society.)

The results of the study point to

several important trends:

*Cigarette Smoking Is on the Rise
Among Teen-Age Girls.*

From 1969 to 1975 cigarette smoking among teen-age girls has increased at the rate of 23%. Translated into people, this increase means that half a million more teen-age girls are now smoking. During this same period of time, however, cigarette smoking among boys leveled off and remained at the 30% level.

*Teen-Age Girls and Young Women
Are Smoking More Heavily than in
the Past.*

During this same period of time, pack-a-day-or-more smoking has increased fourfold among teen-age girl smokers. In 1969, 10% of all teen-age girl smokers smoked at least a pack a day, compared to 39% now. Boys, on the other hand, continued to smoke at the same levels as before.

For while smoking incidence has shown only a slight increment among young women (34% in 1965; 36% now), the proportion of heavy smokers has accelerated sharply. According to the U.S. Health Survey conducted in 1965, one out of two young women smokers (51%) were smoking at least a pack of cigarettes a day. By 1975, the figure was 61%, with the sharpest increase among the more-than-one-pack-a-day group (up from 9% in 1956 to 25% now).

*Yet, the Antismoking Message Has
Been Heard.*

This increase in the numbers and intensity of cigarette smoking among young women and teen-age girls has occurred at a time when these young people were at least intellectually fully aware of the hazards of smoking. Among young smokers, 56% of the teenage girls and 62% of the young women believe wholly or in part that smoking is as addictive as illegal drugs. Yet they still smoke and start to smoke in greater numbers and with more frequency than in the past.

*The All Pervasive Smoking Environ-
ment.*

While young people continue to be aware of the antismoking message, the situation all around them and their own perceptions of who and how many people smoke more than counterbalances the impact of what they have seen, heard or read about the dangers of smoking.

For example, among teen-age girl smokers:

—66% say that half of their friends or more smoke.

—87% smoke with their parents' knowledge; 34% with their parents' approval.

—84% have fathers who smoke or smoked; 64% with mothers.

Add to this the fact that:

—49% of the teen-age girls who smoke report that their schools have special "smoker" rooms where it is permitted to light up during the school day.

—And 68% of the teen-age girls who smoke indicate that their own doctors have not warned them against smoking.

Fewer Antismoking Commercials.

Another key factor, too, is that awareness of antismoking television commercials has been cut drastically as a result of the retrenchment of free matching time following the barring of cigarette advertising on television. In 1969, 88% of all teen-agers reported that they had seen or heard an antismoking television commercial in the past 4 weeks. Currently, only 48% are exposed to this type of television spot. On the other hand, the kinds of people identified with cigarette advertising include the following:

Attractive, sexy, enjoying themselves, young, well dressed, and healthy.

(Report findings will be continued in the April *Journal*.)

* * *

**Every Physician's Office—A Cancer
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WILLIAM M. DUGAN, JR., M.D.
President, Indiana Division
American Cancer Society

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- Quickly relieves painful symptoms such as burning and pain associated with urgency and frequency.
- Recommended antibacterial therapy: up to 3 days with Azo Gantanol, then 11 days with Gantanol (sulfamethoxazole).

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura,

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli*, *Klebsiella-Aerobacter*, *Staph. aureus*, *Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

*nonobstructed; due to susceptible organisms

hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); G.I. reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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* WARNING

This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium[®] (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

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Some diseases can be eliminated by prophylaxis. Smallpox is approaching this state. Tuberculosis is still far away from obliteration. Vigorous chemoprophylaxis will aid in eliminating this scourge.

Isoniazid Chemoprophylaxis

JAMES T. DEPPE, M.D.
Indianapolis

ISONIAZID (INH) was first introduced into clinical use in the 1950s for the treatment of active tuberculosis. Over the past decade or more a new use has greatly increased the numbers of people taking isoniazid—namely, chemoprophylaxis. With the more widespread use of INH, serious toxicity and occasional death have been reported. This article will review the background for the use of isoniazid in chemoprophylaxis, the incidence of asymptomatic and overt liver toxicity, clinical manifestations and the mechanism of liver damage, and the current recommendations for use.

Over a 10-year period, an adult tuberculin reactor with a normal chest radiograph has a 0.6% chance of developing active tuberculosis. If the initial chest radiograph is abnormal, the chance of active disease is 5 to 7%.¹ It is to these two groups of people that isoniazid chemoprophylaxis is directed. Ferebee² reported a 68% reduction in new cases of tuberculosis among tuberculin reactors treated with isoniazid during a 10-year period. In this large series of 36,000 patients, no hepatitis or jaundice was reported and side effects leading to discontinuation of the drug occurred in only 0.47 to 2.8% of patients, depending on age.²

During the first 20 years of isoniazid use it was implicated only occasionally as a cause of hepatitis.³ In most of these reports, however, the patients were also receiving other potentially hepatotoxic agents such as para-aminosalicylic acid (PAS) or streptomycin. With the advent of chemoprophylaxis, many patients have been treated with isoniazid alone. Isoniazid toxicity was brought to national attention in a 1970 report from Washington in which there were two deaths among 19 cases of hepatitis.⁴ Liver biopsies demonstrated a hypersensitivity-like reaction that could not be clearly separated from viral hepatitis. Since that time numerous reports of isoniazid hepatitis have been published. A report of 14 patients seen over a five-year period in Baltimore was published in 1973 and three patients died.⁵ Of the remaining 11, eight had bridging or multilobular necrosis or both on liver biopsy. Rechallenge in two cases produced a recurrence of the hepatitis. The longer the INH was continued, once the patient was symptomatic, the more the liver was damaged, as assessed by liver biopsy.

One of the main problems in considering the potential hepatotoxicity of INH is that a significant number of patients taking isoniazid remain asymptomatic but display biochemical evidence of hepatic damage. Mitchell, Long and Thorgeirsson⁶ reported a study of the incidence of asymptomatic ele-

vation of liver function tests in a series of patients confined to a mental institution. A control group was comparable in age, sex, race, concurrent medications and psychiatric diagnosis. In the study group, 38% of patients had at least one elevation of SGOT above normal, while only 15% of controls had at least one SGOT above normal. Other variables, such as isoniazid serum concentration and fluorescent antibody determinations, did not correlate with elevated serum transaminases. The overall incidence of asymptomatic elevations of transaminases was 20%. Other studies have also reported the incidence of asymptomatic elevations of liver function tests to be in the range of 10 to 20%.^{7,8}

If the incidence of asymptomatic liver damage is 10 to 20%, what is the incidence of clinically overt disease and how does the disease present clinically? The largest series, a United States Public Health Service survey reported in 1975, consisted of 114 patients who developed hepatitis out of a total 13,830 patients receiving isoniazid.⁹ The clinical features were drawn from hospitalized patients only. The onset of symptoms was variable, with 46% of the patients becoming symptomatic within the first two months. Gastrointestinal symptoms were the major presenting complaint in 55% of the patients. The complaints ranged from mild abdominal distress to nausea, vomiting and anorexia. Ten percent of

From the Department of Medicine, Pulmonary Medicine Section, Indiana University Medical Center, Indianapolis.

Reprint requests to Dr. James T. Deppe, University Hospital, N559, 1100 W. Michigan St., Indianapolis 46202.

the patients presented with jaundice. Fever, rash, eosinophilia and joint pains were uncommon presenting complaints. Physical examination demonstrated hepatomegaly and liver tenderness in only 33%.

Serum transaminase was elevated in approximately 90%, alkaline phosphatase in 95%, and bilirubin in about 70%. Twenty five percent of the patients had a bilirubin greater than 20 mg/dl and this was associated with a poor prognosis. Hematocrits and leukocyte counts were generally normal. Prothrombin times were elevated in 20 of 54 patients tested, and 12 of these 20 patients died. Hepatitis associated antigen was negative in the 65 patients tested.

Thirteen of the 114 patients (12.3%) with hepatitis died. Eleven patients had fulminating liver disease, surviving from 4 to 14 days. The severity of the disease seemed less, the earlier in the course of isoniazid chemoprophylaxis the patient developed symptoms. Of 46% of patients symptomatic within the first 8 weeks, only 2 died. Deaths among black females was higher, accounting for 9 of the 13 deaths. That black females seem to be at greatest risk of dying has previously been suggested.⁵

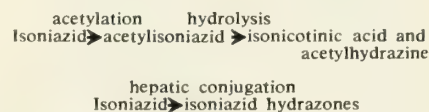
Hepatitis rapidly remitted after discontinuation of isoniazid. In the study group, the serum transaminase decreased by 63% in the first week and 87% by the third week. The bilirubin also decreased rapidly after discontinuation of the drug, 44% in the first week and 72% by the third week.

Maddrey and Boitnott have previously suggested that isoniazid hepatitis is an allergic or hypersensitivity disease.⁵ Drugs such as sulfonamide, PAS and oxyphenasitin are also included in this category. The usual course is characterized by: (1) high incidence of rash, fever, and eosinophilia, (2) prompt recurrence after rechallenge, (3) a relatively fixed period of sensitization of 1 to 4 weeks, (4) eosinophilic inflammatory response on biopsy and, (5) no dose-related injury in animal models. Such is not the case for isoniazid hepatitis.

Histologically, the tissue response in isoniazid hepatitis was one of hepatocellular inflammation and necrosis, but the histologic response also included more chronic changes in some cases. In addition to a histologic picture resembling acute viral hepatitis, some patients had evidence of micronodular and macronodular cirrhosis. In the more severe cases, examples of massive and submassive necrosis were found.

From these studies, a pathologic mechanism could not be defined, although it seemed clear that it was not an allergic response. Orientals receiving isoniazid chemoprophylaxis were found to be more susceptible to hepatic injury.⁸ Since 90% of the oriental population are rapid acetylators,¹⁰ the mechanism might involve a normal metabolic pathway. An initial study of a group of 26 patients with isoniazid hepatitis revealed that 86% of the group were rapid acetylators.¹¹

Isoniazid is metabolized in a series of steps by acetylation and conjugation, as shown below. For simplicity, only the compounds and chemical reactions are included.¹²



Fast acetylators in this study¹² excreted 94% of an isoniazid dose as acetylisoniazid or one of its hydrolytic products, whereas slow acetylators excreted only 63% by this route. This suggested that acetylisoniazid or its hydrolytic products were responsible for liver injury, since rapid acetylators have a higher incidence of isoniazid hepatic injury.

A series of experiments done in rats clearly demonstrated that acetylhydrazine was the chemical agent responsible for liver injury.^{11,13,14} The next question raised was how did acetylhydrazine cause hepatic damage? In the metabolism of some drugs, active intermediates may be formed which are bound or fixed to tissues. Such an example is acetaminophen, which has a macro-molecular intermediate which has

been shown to covalently bind to hepatic tissues before causing damage. A series of binding studies demonstrated the acetyl portion of acetylhydrazine was the intermediate that bound to liver tissue before necrosis occurred.^{13,15,16} A number of possible metabolites of acetylhydrazine has been identified. Although which metabolite is responsible for necrosis has not been firmly established, it has been well demonstrated that some metabolic product of acetylhydrazine is responsible for hepatic necrosis. These studies have demonstrated that hepatic damage due to isoniazid is a function of a normal metabolic pathway which, because of its varying reactivity in different persons, may produce hepatic damage in otherwise normal individuals.

Every person with a positive tuberculin skin test can potentially develop active tuberculosis. The risk is for life and consequently it is the younger population that would benefit more from chemoprophylaxis. In addition, the incidence of INH hepatitis increases with increasing age. The following recommendations for chemoprophylaxis are based on age and complicating factors. In persons under 35 years of age, the potential benefits of INH chemoprophylaxis outweigh the risks; consequently these individuals need not fulfill any other criteria.¹⁷ At present, a joint statement of the American Thoracic Society and the Center for Disease Control recommends that chemoprophylaxis with INH in persons over 35 years of age be evaluated on an individual basis and considered if an individual meets one of the indications below.¹⁷

1. *Household contacts or other close associates.* This population is at high risk of developing active tuberculosis because of their intimate contact with an active case prior to the diagnosis and treatment of that active case. All persons in this group should be evaluated with a tuberculin skin test and chest radiograph. Some subsets of this group, especially children and spouses, should receive chemopro-

phylaxis regardless of the results of their skin test. If the initial skin test is negative and if chemoprophylaxis is not prescribed initially, this group should be skin tested every three months and convertors treated accordingly.

2. *Stable abnormal chest radiograph and negative cultures.* Persons with stable abnormal chest radiographs consistent with tuberculosis are candidates for chemoprophylaxis if they have never received antituberculosis medications and are culture negative. Reactivation rates, if untreated, have been found between 1 and 4.5% per year.

3. *Newly infected persons.* The risk of developing active tuberculosis is 5% in the first year after infection. The term "newly infected" is used for anyone who has converted their skin test within the past 2 years.¹⁷ A convertor is defined as a person whose tuberculin skin test has increased from less than 10 mm induration to greater than 10 mm induration by at least 6 mm induration.

4. *Special clinical situations.* Patients with a positive tuberculin skin test in conjunction with the following conditions are at greater risk than the normal population and should receive chemoprophylaxis. These situations are corticosteroid therapy, immunosuppressive therapy, leukemia, Hodgkin's disease and

other lymphomas, diabetes mellitus, silicosis, or partial or complete gastrectomy. In many of these patients skin testing may result in a large number of false negative results. It could be argued that persons with the above conditions should receive chemoprophylaxis regardless of their tuberculin reactivity. There is no evidence that continuation of chemoprophylaxis beyond one year is beneficial.

Isoniazid liver damage is usually asymptomatic and can be detected with routine liver function testing. In clinically overt cases the course is similar to viral hepatitis. Malaise, anorexia and nausea (with or without vomiting) may develop before jaundice. An otherwise asymptomatic individual may develop jaundice without preceding symptoms. A serum sickness-like illness of fever or hepatomegaly is not common. The illness can occur from the first week to many months after the initiation of isoniazid chemoprophylaxis. In most cases, spontaneous recovery occurs after withdrawal of the drug, but some individuals may progress to permanent liver impairment or death.

Because of the high mortality of INH hepatitis, Mitchell and his co-workers at the National Institutes of Health suggest that INH chemoprophylaxis be monitored with frequent serum transaminases and the drug

be discontinued when biochemical evidence of hepatitis develops.¹⁴ What constitutes a significant elevation of serum transaminases is not entirely clear. Most authorities suggest, however, that hepatitis is unlikely with elevations less than 2 to 3 times normal.^{17,18} On the other hand, because of the low incidence of clinically overt hepatitis, most authorities feel it is sufficient to monitor the patient's clinical course. The Tuberculosis Advisory Committee of the American Thoracic Society does not recommend the routine determination of serum transaminase but agrees the transaminase is useful in evaluating signs or symptoms of hepatitis.^{17,18} The only real controversy about the rationale for INH chemoprophylaxis and its relation to hepatic damage is whether to monitor the clinical course or monitor the serum transaminase of the patient on isoniazid.

ACKNOWLEDGEMENT

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(A copy of the references pertaining to this paper may be obtained by writing The Journal office, 3935 N. Meridian St., Indianapolis 46208.)



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Muscle Ruptures

JOSEPH D. GODFREY, M.D.
Buffalo, N.Y.

MUSCLE rupture is said to be caused by an intrinsic overload when the injury occurs near the midpoint of the contraction. Extrinsic overloading occurs when the musculo-tendinous structure is stretched to its greatest length.

Diagnosis

It is evident that the history is essential, for if the rupture occurs in the midportion of the action, when the contractile component is unduly overloaded, the strain or rupture will invariably be within the substance of the muscle proper. If the overloading is at the stretch-overstretch phase, the origin, insertion or musculotendinous unit will be the area of involvement. Probe the past for aspects of conditioning, previous injuries and other areas which might add to the history.

From there we go to the examination, evaluating:

1. Gait.
2. Protective splinting.
3. Contours.
4. Active ranges of motion (re-

Excerpted from a talk given before a recent meeting of the Indiana Orthopaedic Society in Evansville. Dr. Godfrey is clinical professor of orthopaedics at Buffalo State University, is a past president of the American Society of Sports Injury and is attending surgeon for the "Buffalo Bills."

cord for comparative subsequent study).

5. Swelling.
6. Tenderness.
7. Pain on motion, stretching, palpation and judicious resistance.
8. Passive ranges of motion (record as above).
9. Loss of power.

Treatment (usually post facto)

When a reasonable diagnosis has been arrived at, treatment follows. It will vary depending upon whether you are dealing with mild, moderate or severe disruption. However, there are a few basic early measures for all:

1. Rest it. (Bed confinement and traction if necessary.)
2. Cool it.
3. Elevate it.
4. Compressively wrap it.
5. *Don't* massage it, don't heat it, don't stretch it, don't aspirate it, and, from my experience, don't inject it.
6. Crutch walk the patient.
7. Cast for a short number of days, if necessary.

After the first 24 to 48 hours, gentle specific active treatment may be initiated if the course is to be a conservative one. (There are occasions when surgery is the conservative treatment.) With subsi-

dence of local signs and symptoms, the use of heat, whirlpool, low intensity ultrasound, gentle massage and active stretchings, isometric to isotonic or isokinetic exercises are in order. Passive stretching and exercise progress to active assisted, then active and, finally, active resisted.

Oral enzymes may or may not have status in the overall management. Personally, I seriously question their value.

Evidence of full motion, normal power, no localized signs or symptoms will then permit the individual to go on to active sports participation. Reinjury from too early a return to activities most certainly delays recovery.

Steroids do not have a role in the treatment of muscle ruptures because:

1. After one week there is mitochondrial swelling and early lipid vacuolization of some fibers.
2. After two weeks there are evidences of generalized atrophy with increased sarcolemmal nuclei and increased vacuolization.
3. After the third week a significant number of muscle fibers become necrotic.

77 Bryant St.
Buffalo, N.Y.

In Brief . . . A Summary of AMA Medical and Health News

No organization rates higher than the AMA in public credibility, according to a recent Gallup poll. The poll tested the public's belief in communications of all types from government agencies, labor unions and professional and trade associations. The AMA ranked 6.8 on a 10-point scale, while the average for professional associations was 6.5. The average rating for trade associations was 5.1, for government agencies 5.7, and for labor unions 5.4. In one portion of the poll the public demonstrated its belief that AMA actions are in the public interest by giving the Association a high 6.6 rating.

The multitude of pathogens involved in pneumonia and the variability of antibiotic sensitivity of each bacterium make culture and sensitivity tests indispensable.

The Comparative Value of Sputum and Blood Cultures in the Diagnosis of Acute Bacterial Pneumonia

MOHAMMED NASSER SHINWARIE, M.D.
Jalalabad, Afghanistan

Introduction

ACUTE bacterial pneumonia is usually diagnosed on the basis of the physician's judgment, considering clinical information, gross and microscopic evaluation of sputum and chest roentgenographic abnormalities.¹ Antibiotics are immediately administered, since early diagnosis and treatment are necessary in reducing morbidity and mortality of the disease.² Culture reports of sputum, pleural fluid, blood and, rarely, lung tissue take several days. The concern of this study was directed toward the relative value of sputum and blood cultures in the confirmation of the provisional clinical diagnosis. The medical records of 45 patients with acute bacterial pneumonia and bacteremia were examined and a correlation was made of the frequency of similar bacterial pathogens in the sputum and blood cultures of each patient.

Methods and Materials

Medical records with the discharge diagnosis of acute bacterial pneumonia and bacteremia were evaluated for several criteria: The patient must have had clinical and

chest x-ray evidence of acute bacterial pneumonia as well as positive cultures of sputum and blood for bacterial pathogens. Forty-five such charts from Wishard Memorial Hospital over the time period 1970-1975 were found. Individuals in this group were from a wide age distribution and were of both sexes and various races. The presence of underlying disease was noted. Prior or concurrent usage of antibiotics at the time of culture resulted in elimination of that record from the study group. Gram stain information was also obtained. Tables were then prepared showing the types of organisms cultured and the similarity of isolates from the sputum and blood cultures of the same patient.

The cultures were routinely prepared by and reported from the hospital laboratory. Collected sputum was streaked on blood agar, azide, of MacConkey plates; thio-

glycolate broth was inoculated in a CO₂ atmosphere. Organisms were identified by hemolysis reactions, coagulase activity or fermentation patterns, and antibiotic sensitivities were determined.

Results

The medical records of 230 patients were reviewed; of these 45 (35%) were selected, using the previously described criteria. Sputum cultures were positive for a variety of organisms in 140 individuals (60%). The incidence and distribution of positive blood cultures regarding sex, age and race is shown in Table I: It is clear from this information that men were more likely than women to have positive blood cultures (69%), that the age group of 60 years or more showed the highest frequency of positive cultures (44%), and that blacks exceeded whites with positive

TABLE I
The distribution of blood culture in 45 patients regarding sex, race and age in number and percentage

Sex		Race		Age	
Male	Female	Black	White	10 yr	11-20 yr
33 (69%)	15 (31%)	27 (56%)	21 (44%)	2 (4%)	2 (4%)

Age				
21-30 yr	31-40 yr	41-50 yr	51-60 yr	60 yr
4 (8%)	7 (14%)	4 (8%)	8 (16%)	21 (44%)

Dr. Shinwarie was a Special Fellow in Pulmonary Diseases at the Indiana University Medical Center when the accompanying article was written. He is presently on the faculty of the Nangrahar Medical School, Jalalabad, Republic of Afghanistan.

TABLE II

The incidence of bacteria in blood cultures of 45 patients and correlation with sputum cultures

	Number of patients with positive blood cultures	Number and percentage of patients with positive sputum cultures	Concomitant underlying disease
Diplococcus pneumonia	19	8 (42%)	2-alcoholism 2-diabetes mellitus 1-multiple myeloma 1-arteriosclerotic heart disease 1-hypertension
Staphylococcus albus	13	1 (3%)	
Staphylococcus aureus	8	7 (87%)	1-alcoholism 2-infectious endocarditis 1-diabetes mellitus 1-acute respiratory failure
Streptococcus species	3	—	—
Pseudomonas aeruginosa	3	—	—
Klebsiella pneumonia	1	1 (22%)	—
Serratia	1		Carcinoma of tongue
Bacteroides species	1	1 (2%)	—
Escherichia coli	1	—	—
Enterobacter	1	—	—
Flavobacter	1	—	—
B. subtilis	1		
TOTAL	45	19 (42%)	

cultures (56%). One notes in Table II the correlation of similar isolates of bacterial pathogens in the sputum and blood of the patients. Not surprisingly, pneumococci were the most frequently isolated organism from the bloodstream of these patients. Of those individuals with positive blood cultures for pneumococcus, only eight (42%) were found to also have the organism in the sputum concomitantly. On the other hand, *Staphylococcus aureus* cultures of blood and sputum showed an 87% positive correlation. The remainder of the organisms occurred too infrequently in number to allow correlation studies. Table III shows the mixed nature of the sputum culture organisms. The flora varied from only one organism in

10% of samples studied to two to seven organisms grown per sample in the remaining 90%. Finally, Table IV depicts the various organisms isolated from the sputum samples and the relative frequency of these organisms.

Discussion

The value of the sputum culture in diagnosing acute bacterial pneumonia has been questioned.¹ Spu-

tum samples may be difficult to obtain from some patients; furthermore, expectorated sputum may be contaminated by oropharyngeal bacteria.⁹ Bacteria are frequently distributed unevenly in the sputum, leading to conflicting reports from the laboratory.¹⁶ Also, pathogens such as pneumococci can be found not infrequently in sputum from patients who do not have pneumonia. Patients who have pneumonia diagnosed from cultures of pleural fluid or blood cultures may not have the same pathogen in the sputum.¹

Methods have been developed to improve the yield of pathogenic microorganisms in the sputum. Liquefaction and homogenization procedures deal with the problem of uneven distribution.⁴ Dilution and quantitation technics apply the principle similar to that used in diagnosing urinary tract infections.⁴ These processes are usually cumbersome and expensive, but do improve the yield.

Obtaining and examining sputum has been complicated. Trans-tracheal aspiration increases the yield of pathogens and reduces the number of contaminants; however, it is not a benign procedure and has led to subcutaneous emphysema and hematoma formation.⁹ Aerosols have been used effectively to increase sputum production. The Quellung reaction expedites the identification of pneumococci.²

Also, cultures of pleural fluid, blood or the lung tissue itself have been considered important correlates with the sputum culture. According to Lepow, the gram stain of sputum is approximately 50% better in detecting pneumococcus than are cultures for pneumococci.¹ Our report substantiated the unreliable nature of the sputum culture for pneumococci with respect to blood cul-

TABLE III
Mixed flora in the sputum of 140 patients

Number of organisms						
One	Two	Three	Four	Five	Six	Seven
10(8%)	21(16%)	29(22%)	28(21%)	22(17%)	13(10%)	10(8%)

tures; however, this was not true for *Staphylococcus aureus*. Although our data for gram-negative organisms were sparse, Barrett-Conner suggests that the presence of gram-negative organisms is important and should be heeded with a note of caution.

Interpreting the mixed flora data one can make note of the very unlikely possibility that *Diphtheroids*, *Neisseria catarrhalis*, *Bacillus* species, and *Staphylococcus albus* could be pathogens. The other organisms must be considered pathogens and studied in terms of other cultures and clinical conditions; for example. *Hemophilus influenza* would be considered important in the sputum of a patient with chronic obstructive lung disease.

In conclusion, we consider blood cultures very important diagnostically.³ Individuals likely to have positive blood cultures, according to this study, would be older black men. The sputum culture is important particularly when it shows an organism other than pneumococcus,

TABLE IV
The incidence and frequency of bacteria recovered from the sputum of 140 patients

Microorganism	Number of Patients	Percentage of Patients
Streptococcus (alpha)	107	80%
Neisseria catarrhalis	100	75%
Diphtheroids	48	36%
Streptococcus (non-alpha or beta)	37	28%
Staphylococcus albus	36	27%
Diplococcus pneumonia	32	26%
Staphylococcus aureus	34	25%
Klebsiella pneumonia	19	14%
Escherichia coli	19	14%
Pseudomonas aeruginosa	18	13%
Streptococcus (beta)	15	11%
Enterobacter	12	9%
Citrobacter	10	7%
Proteus mirabilis	8	6%
Serratia	6	4%
Hemophilus influenza	5	3%
Bacillus subtilis	2	1.5%
Bacteroides	1	0.8%
Herellia vaginicola	1	0.8%

such as *Staphylococcus aureus* or gram-negative bacilli. Refined techniques such as homogenization or dilution should perhaps be considered in special situations, because the

contamination of sputum was evident from our reports. We must emphasize, however, the composite nature of all the factors in diagnosing bacterial pneumonia. ◀

There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

Thoracic Spine

FOR at least 15 years, and probably longer, the part of the spine that supports the ribs and helps form the thorax has been officially named the "thoracic spine." Younger and middle-aged physicians have been taught to call it the thoracic spine.

But, in practice, most physicians, nurses, technologists etc. call it the "dorsal spine." If you don't believe me, look at the x-ray requests in your hospital.

A little thought shows us that "dorsal spine" is a crass misnomer; the whole spine or vertebral column is dorsal; none of it is ventral. To single out one segment of the entire spine and call this segment the "dorsal spine" implies there is at least one portion of the spine that is ventral. And this usage is implicitly stupid. We know better.

Why then do we call it the "dorsal spine" clinically?

Probably because of habit and

because "thoracic" has three syllables, while "dorsal" has two syllables. So the briefer and more ingrained term lives on in clinical medicine, with the correct "thoracic spine" used seldom.

As doctors, we have an obligation to teach, primarily by our example. It doesn't take much effort to think, say and write "thoracic spine," rather than "dorsal spine."

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3935 N. Meridian, Indianapolis, Ind. 46208

The Use of Thermography

THERE appears to be difference of opinion as to the importance and/or efficacy of use of thermography in study of breast lesions.

There is also considerable discussion concerning the use of mammography. Its capabilities are amply demonstrated but details of its use as a screening procedure are debatable and probably will be for quite some time. If it is to be recommended to all women as an instrument of early diagnosis of malignancy, at what age is it to be commenced and at what intervals should it be repeated?

Thermography is a non-invasive technic. Mammography is invasive and differs from invasion by surgical and vascular-injection methods in that the long-term side effects are not well known and won't be well known until clinical experience with it has added up to many years.

Each of these diagnostic methods is subject to discussion. There is, in addition to questions within each modality, even more debate about the relative value of thermography and mammography and about the proper use, if any, of each in relation to the other.

This is natural since both entities are relatively new and both require further experience and probably many years of experience before the exact role of each is determined.

The President of the American Thermographic Society, Dr. Gerald D. Dodd, professor of radiology at M. D. Anderson Hospital of the University of Texas System Cancer Center in Houston, has written to the Federal Drug Administration to protest comments about thermography in the FDA Drug Bulletin.

Dr. Dodd writes:

While there is unanimous agreement that the modality (thermography) should

not by itself be used for purposes of cancer detection, all knowledgeable in the field concur that it does increase the efficiency of the screening program when used in conjunction with physical examination and mammography. The usefulness of thermography in a screening program is primarily related to indeterminate mammographic or physical findings. A positive thermogram under these circumstances may result in a biopsy when the procedure was not clearly justified by the radiographic or physical findings. This use of thermography has resulted in an increase of 3 to 5 percent in true positive rates in most screening series. This application cannot be overlooked in a procedure which is non-invasive (radiation-free) and relatively inexpensive.

Dr. Dodd's letter continues:

Finally, the use of thermography for the serial follow-up of younger women who have had baseline studies is probably warranted. Early changes in the thermographic pattern may herald the advent of significant pathology in the breast and indicate the need for additional mammography. *In the present climate related to the potential carcinogenic ef-*

fects of radiation, this capability of the (thermographic) instrument cannot be neglected.

And there is more. The American Thermographic Society has released an official statement:

An abnormal breast thermogram is an indication for mammography because of its significance as a risk marker for cancer of the breast, either current or prospective, and in breast cancer detection thermography has a complementary role to physical examination and mammography in the decision-making process.

Guest Editorials

Doctors Caught In Crossfire

TODAY many people believe a physician practices an exact science with an answer for most every one of their medical problems. Our government accepts this attitude.

Since the early 1950s our legislators in Congress have been wrestling with the idea that free medical service for all is a right—a right without a corresponding responsibility. Young men and women have entered this profession with a dedication to helping their fellow man. It is a relationship to help heal but not one to be directed by the legislative process.

Gradually the emotional appeal for votes by congressional candidates sympathetic to a form of free medical care for all the elderly (Medicare) and all the poor (Medicaid) resulted in the enactment of these programs. Traditionally physicians have been rendering a considerable amount of free medical care to the indigent. The warning by the profession of the exorbitant cost and the erosion of the physician-patient relationship has been borne out by the experience of these government-reimbursed programs.

At present, in the age of gadgets in medicine and political rhetoric, the appeal by the legislator is again being heard. On the one hand, government tells the physician "You must be paid for services rendered to everyone." Then the physician hears, "You are charging too much. The program is too costly."

Actually physician cost is the smallest item in the budget for

health care. Hospitals, technical equipment, over-utilization, insurance premiums and inflation are much more significant contributors to the rising cost of health care.

Physicians are dedicated to the care of their patients, and resist intervention by government and third party payers in the control and management of the sick. When a family wants no effort spared to prolong a life, even if nothing but vegetative existence remains, or when patient or family wants extra days in the hospital for convenience alone, what is the physician to do?

At the same time, as the government becomes more deeply involved with payments, regulations and standards, the doctor is increasingly pressured to shift his allegiance to become the government's agent rather than the patient's.

There is no way the doctor can avoid this dual allegiance, first to the patient, but now also to a third party, so long as that third party pays the bill. But when a doctor does try to act on behalf of society and help keep the costs down, there is nothing to prevent the patient from attacking him. Resenting the inadequacy of reimbursement the patient may conjure up a malpractice suit and such suits most often arise when the patient-doctor relationship deteriorates, regardless of the medical fact involved.

Until society acknowledges the physician's expanded responsibility as a trustee of the public's resources and makes it safe for him to promote the general as well as the individual welfare, the physician will remain caught between a rock and a hard place, damned if he does and damned if he doesn't.—**Editorial from The Indianapolis News Dec. 18, 1976, written by Donald E. Wood, M.D., Indianapolis. Reprinted with permission.**

Brand Exchange A Fiasco

EVERY time we write an article about brand exchange or substitution we say to ourselves this has to be the last one and then something occurs that brings us to say

to ourselves we must have one more go at it. Surely someone will listen!

The most recent instance that inspires us to speak out again is taking place in Kentucky.

Kentucky passed a drug formulary law in 1972 which had questionable success. In 1976, a new law was passed making it compulsory for the pharmacist to dispense the cheapest Kentucky formulary product on his shelf. That drug is the one the welfare department will reimburse under Medicaid.

This compulsory requirement is being exploited by consumers. Shoppers have found some pharmacists failing to comply with this law in Kentucky. Now we have the attorney general of the state stating he will bring suit against pharmacists who fail to make the compulsory substitution.

Looking through some of the news articles that have come to our attention from the Kentucky press, we read also that the attorney general is putting heat on county attorneys, who in turn are giving notice that this consumer legislation must be enforced with criminal penalties, if necessary.

Another rumor has it that a class action suit has been brought against a Georgia state agency and the people responsible for developing a restrictive formulary for the state placing these people and the state in an embarrassing situation.

We see evidence that Florida is thinking of adopting a low MAC drug list for Medicaid, that mandatory substitution proposals are being suggested in New Jersey, California and Oregon and the potential of this spreading like wildfire through all the states is readily recognizable.

We have said from the very beginning that there was little to recommend the brand exchange laws, that they would come back to haunt the profession. It has happened much sooner than we expected.

We believe that any pharmacy organization or its officials who extol the virtues of brand exchange laws in the face of the facts as they currently exist, is not acting in the

best interest of the profession.

The future of all providers of health care is at stake in the present controversies. It was a serious error on the part of pharmacy to introduce into the legislatures a "legal solution" to professional responsibilities.

Physicians and pharmacists working together in the best interest of the patients can accomplish everything the law is trying to accomplish, much more effectively and efficiently and without the degrading result that we are presently witnessing.

It is time we got off the brand exchange band wagon and on the health care team. It is time we started working with physicians to better serve patients and it is time to stop trying to solve professional problems in the legislative halls of Congress or the states. Will pharmacy's leadership be up to the challenge?—*Action in Pharmacy, January 1977. Reprinted with permission.*

The Basic Question

WE have always felt that legislative actions are not a panacea for the ill health of the health care system in this country. The basic question is why pharmacists do not substitute cheaper drugs even when they have the law which authorizes them to do so? There are several explanations—they might feel that it is not in their patients' best interest; it is not in their own economic and professional interest, it is "unethical" to circumvent the prescriber's prerogative and so on. Another set of reasons could be that the pharmacists do not have faith in the cheaper version of the prescribed drugs; they do not like to "rock the boat," they are not confident that drug products of two manufacturers are truly equivalent. None of the studies has investigated these aspects in detail. Perhaps the time limitations preclude these, but the basic question still is unanswered—why the intended substitution almost never happens. Could it be that the pharmacists feel that they *should not*.

Finally, when the pharmacists do make up their minds to substitute—

what products will they select in place of the ones prescribed? We suggest that you read *American Druggist*, November 1976 issue, for the pharmacists' preferences. In short, they select the products made by major reputable manufacturers. Perhaps the pharmacist is the last health practitioner who knows the meaning of the term "quality" of a product.—**"Our Opinion" in *Action in Pharmacy*, January 1977. Reprinted with permission.**

Words from the Speaker

HERE is no possible way of presenting a comprehensive review of affairs being considered by the various committees and the ISMA Board of Trustees. But let me assure you that detailed information is being forwarded to your county secretary promptly after official action is taken.

The policies and protocol of organized medicine are not clouded in mystery or deception, as you may surmise. On the contrary, absolutely nothing is hidden or made unavailable to any member who may be interested or curious enough to make inquiry in no longer time than it takes to dial the headquarters WATS line (1-800-382-1721).

To glean information on any one item is like trying to focus on a single raindrop amidst a downpour. Without an executive secretary, the county society secretary has an exercise in futility remaining informed concerning the "affairs of State." Alas, if only we had had the foresight years ago to invest in the paper industry!

The various topics I choose to write about are not to be inferred to be the most important. They are chosen because I have found them easier to present in an interesting and more readable manner, thereby, perhaps, motivating more widespread participation in the affairs of organized medicine among the general membership.

My topic this month concerns a rather subtle and extremely fascinating subject being seriously considered by your Future Planning

Committee: Feasibility Study For Computer Applications. This matter brings forth multiple ramifications that ultimately will elicit much debate and action by the House of Delegates.

Back in yesteryear when organized medicine was being pressured into Peer Review programs, ISMA spawned a foundation known as I-MEDIC. Subsequently, however, our clever federal bureaucrats prostituted the concept of Peer Review into the ignominious one which we now must deal with known as PSRO or "Pissaroo." (Hopefully, the latter entity will always remain extrinsic to organized medicine.) The two concepts are totally dissimilar!

Dr. Peter Petrich (with able assistance of others) took the "foundling infant," Peer Review, and tenderly nurtured it through the auspices of I-MEDIC. Too many have mistakenly assumed PSRO to be a form of Peer Review. The bureaucrats cleverly created the monstrosity, PSRO, to replace the more docile and rational "child" they so quickly orphaned when they realized Peer Review was not to become a puppet to be manipulated at their every whim.

Tenaciously ministering to his "charge," as directed by ISMA, Pete is prepared to unveil the results of his labor, and the product appears to have great promise of providing a sane and sensible future for the practice of medicine and quality health care.



"Now where were we? Oh, yes..."

The heart of this mechanism lies in computer applications, and the Indiana State Medical Association enlisted the services of a well qualified specialist, Mr. James Quinn, director of membership information systems for MMS, Inc., Chicago. Mr. Quinn was present at the meeting of the Future Planning Committee on Dec. 15 to present a preliminary report.

His presentation seems to open up many new vistas for ISMA to explore which logically would fall within our purview. This modality could conceivably be the salvation of practicing physicians and their patients who are being threatened more each day by encroaching monstrosities spewing forth out of "foggy bottom."

Many of us were made aware of a new semantic at this meeting: "turf." The medical profession has no practical means of obtaining a comprehensive data base amongst its members. This is essential for any sort of meaningful Peer Review. The bureaucrats in HEW, PSRO, HSA, SBOH and even the Medical Licensing Board of Indiana have no data to formulate any actuarially sound premises, let alone conclusions.

Like it or not, health care legislation that makes such data almost indispensable, if for no other reason than to defend ourselves, is erupting out of Washington and state legislatures like from Mt. Vesuvius. However, we could become the agent and custodian of such information, retaining internal control of its dispersal and deriving an income in the process.

Such a facility under our roof and absolute control could be a vital protection to us when being assailed irrationally by whimsical assertions of social reformers in bureaucracy. To date, however, we have no authoritative source to rebut their obvious distortions and gross misrepresentations. We simply know they are not true! (And so do they!) Computer applications would satisfactorily supply us with indisputable facts. ISMA has an opportunity and is the logical instrument to supply this information in the state of Indiana.

Only one other state medical association (Maryland) is as far along as we in developing this sophisticated mechanism. The applications of this mechanism are far and wide in the health care field, and many organizations—governmental, educational, professional, student groups and the third parties—are eager and willing to pay for such information which would remain within our absolute guidance and control. In order that my tongue is extracted from my cheek on that last statement, I am assuming that the House of Delegates would be solely responsible for establishing strict guidelines for the accumulation and dispersal of this data.

The choice is ours. The Future Planning Committee is intently investigating this subject this year. You can rest assured recommendations will be forthcoming for your delegates' deliberation at the annual meeting. Obviously it will call for expenditure of funds as an initial investment, whether the hardware is

leased or purchased. Is it worth it? Study the reports of the Future Planning Committee and decide for yourself. It, at least, is one of the few ventures considered by organized medicine that has meaningful income potential, while at the same time affording us much needed information and protection.

LLOYD L. HILL, M.D.
Speaker of the House
302 N. Duke St.
Peru 46970

Editorial Notes . . .

Ciba-Geigy has challenged the decision of the Florida Board of Pharmacy and State Board of Medical Examiners to omit the antihypertensive drug, Ser-Ap-Es, from the Florida list of drugs which cannot be substituted. The firm validates its challenge by the fact that there is no equivalent product available, and also challenges the basic substitution law on several other grounds.

Swedish researchers continue to demonstrate more and more therapeutic uses for the various prostaglandins. They report that prostaglandin E₁ (PGE₁) will effect a remarkable improvement in the patient with peripheral vascular insufficiency. Ischemic ulcers, pain of ischemic causation and other circulatory deficiencies short of gangrene have improved with PGE₁, administered by arterial infusion. The patients treated include many diabetics. The drug is not available in the U.S. ◀

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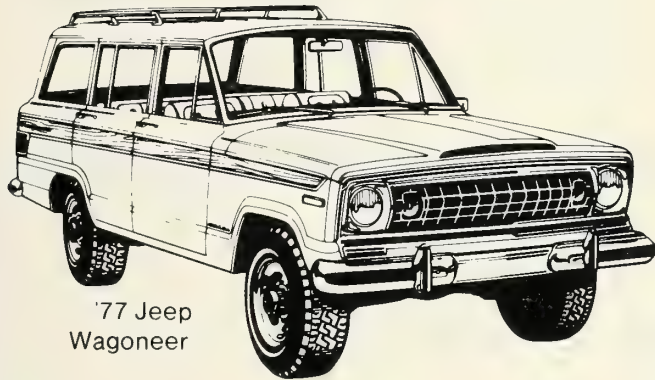
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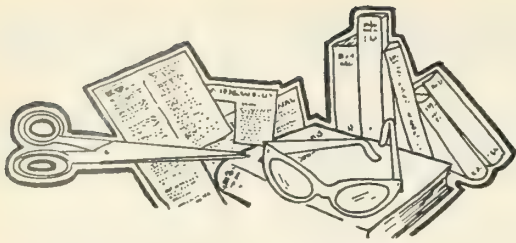
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BOOK REVIEWS

COPING WITH FOOD ALLERGY

Claude A. Frazier, M.D., Quadrangle/The New York Times Book Co., New York, 1974.

Coping with Food Allergy richly deserves the adjectives "authoritative and practical." It is designed for patients and for their physicians as well. Its endorsement by the president of the American College of Allergists adds further to its prestige. The style of writing is such that any intelligent layman can understand it, and yet, the book is not designed as a "do it yourself" opus but rather is a treasure chest of information for the allergic patient who is cooperating with his physician in management of his problems.

Some of the chapter titles give a clue to the contents of the book: "Characteristics of Food Allergy," "How to Ferret Out the Villain," "Milk—The Almost Perfect Food?" In an

effort to be eminently practical, Dr. Frazier has included recipes for allergy-free menus.

Your reviewer, who has been the victim of numerous food and inhalant allergies himself, can say forthrightly that this text makes the best kind of sense and can be recommended wholeheartedly to the allergic patient—and to his physician. The book is hardcover, sells for \$9.95 and has no illustrations (which should not detract in the least from the excellence of the book).

W. D. SNIVELY, JR., M.D.
Evansville

GROWTH, MATURATION AND AGING

Tadayoshi Imaizumi, Kugayama Press, Tokyo, 1976. 118 pages.

The author of this small and so very Japanese volume states that his purpose is to suggest answers to questions such as "Why living things do not exceed a certain size." "Why the phenomenon of reproduction arises" or "Why living things age and die." He might have accomplished these answers in perhaps one-third of the pages in his narrative.

There are 10 chapters and countless repetitions of the idea that a "coacervate liquid drop" is the primitive form of metabolism. The idea is that such a drop absorbs and excretes—spontaneously. The final reason, therefore, for aging is retention of metabolites.

I think it sounds like an interesting speculation. The book is translated awkwardly and not recommended to anyone without a specialized interest in the literature of gerontology and related sciences.

RODNEY A. MANNION, M.D.
LaPorte

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Why Leasing Your Next Car May Be Smarter Than Buying

In America the automobile is no longer a luxury. It's an expensive necessity for our way of life. But more and more, Americans are discovering an economical alternative to buying a car. Today one out of five cars on our roads is a lease car. And the experts predict that within ten years, the number of lease cars in America will increase to seven out of ten.

But isn't leasing just for company cars or people who use them in business?

Not anymore. Of course companies and individual businessmen were among the first to recognize the advantages of leasing. But today, many personal cars are lease cars not used in business at all.

Just what is leasing?

Simply stated, leasing is a way to finance an automobile that offers many benefits you miss out on by buying.

Name one benefit of leasing you can't get by buying.

First of all, leasing a new car frees up your cash. A bank would require a 10% down payment to buy. But when you lease, your only money down is your first monthly payment. So you can invest the cash difference, save it and earn interest, or use it to buy whatever you want.

Then wouldn't my monthly payment be higher?

No. The current interest rate to lease runs about 3% per year less than financing to buy. So your monthly payments are actually lower with leasing. And again, you keep the extra cash difference.

But what if I simply pay cash for a new car?

Just turning the key in a new car can cost you \$800 to \$1,500 or more in depreciation alone. And by tying up your cash, you'll lose the interest you could earn by investing your money.

Will I have anything but cancelled checks at the end of the lease?

It may surprise you to learn you can build equity in a lease car. At the time you select your new car it will be given a residual value, the estimated wholesale price it will be worth at the end of the lease. If your car is then in average condition, (no rust, no serious body damage, and an average of about 15,000 miles per year), it should actually be worth more than the original residual. You then have the option of selling it or we'll sell it for you. And anything above the original residual value is yours to keep.

What about the tax benefits of leasing?

If you do use your lease car for business, your lease payments make it simple to compute and document automobile expenses on your tax return. You also have the advantage of paying for your transportation from current income, before taxes, rather than buying a car from past profits or savings which have already been taxed.

Are there any other advantages to leasing a car?

That depends on your leasing agent. Here at Dave Waite Leasing, our experienced transportation consultants can help you select the lease car that best fits your needs. They can advise you on makes, models and options that provide the best possible resale value. And they'll even arrange for your auto insurance.

What kind of car can I get from Dave Waite Leasing?

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The Auxiliary Reports to ISMA

Dear Doctor:



"We, the public, are the victims of television and newspapers. Newspapers pride themselves on printing the news, as it is, as free from prejudice as possible and television makes no claims except to be entertaining. Therefore, physicians frequently are reported and depicted as unfaithful to wives, narcotic addicts, handsome young fellows with not much on their minds but nurses, making grave errors in surgery or diagnosis, heroes in discovering some rare something or other, and generally being described in terms that very few physicians would recognize themselves.

"Most physicians are dedicated human beings that represent a lifeline to gravely ill people. They are also the confidant of many people who suspect they are ill but really

need someone to talk to. While a physician practices his profession, he often spends many hours in surgery, which is physically exhausting. He also experiences frustration in confronting a baffling diagnosis, which is mentally exhausting. And, these human beings called doctors must often be a father, a son, a husband, a business executive, arbitrator, or community leader, and many times all at once.

"The Auxiliary recognizes many facets of a physician. The Auxiliary seeks to assist the doctors in their community and health projects and in March, the Auxiliary would like to say publicly, 'Doctors, we thank you!' "—Published in the "Letters to the Editor" column of area newspapers on Mar. 30, 1976, by the Auxiliary to the Berrien County (Michigan) Medical Society.

Chloe A. Goldsmith

Chloe (Mrs. David A.) Goldsmith
President, ISMA Auxiliary

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AMA Expands Continuing Medical Education Opportunities in 1977.



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Recognizing the importance of continuing medical education to its members, the AMA has greatly expanded its CME programs. During 1977, the AMA will offer 15 regional CME meetings around the country in addition to its scientific programs at both the Annual Convention and Winter Meeting.

The purpose of the regional programs is to make it easier and more convenient for you to continue your medical education by bringing the meetings closer to your hometown and by scheduling them on the weekends to

avoid interference with your practice.

All courses are approved by the AMA Council on Continuing Physician Education for Category 1 credit toward an AMA Physician's Recognition Award. A syllabi written by medical school faculties is provided with every course.

Specific information on course location, fees, academic program, faculty, and hotel reservations will be available approximately 2 months before each course date. Please write to address below at that time stating your selection(s). Print name, address, and office phone number.

1977 Regional Schedule

Tulsa, Oklahoma	January 22-23
Birmingham, Alabama	February 5-6
*Lake Tahoe, Nevada	February 11-13
Denver, Colorado	February 19-20
*Tarpon Springs, Florida	March 4-6
Detroit (Southfield), Michigan	March 26-27
New York (Westchester), New York	April 16-17
Houston, Texas	May 15
Hartford, Connecticut	September 10-11
*Lake of the Ozarks, Missouri	September 16-18
Chicago, Illinois	September 24-25
*Hot Springs (Homestead), Virginia	Sept. 30-Oct. 2
*Huron, Ohio	October 7-9

*Honolulu, Hawaii	Oct. 30-Nov. 4
Hershey, Pennsylvania	November 18-19

AMA's 126th Annual Convention

San Francisco, California	June 18-22
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AMA's Winter Scientific Meeting

Miami Beach, Florida	December 10-13
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AMA Spokesmanship Seminars

Chicago, Illinois	August 13-14
(Marriott O'Hare Hotel)	November 12-13

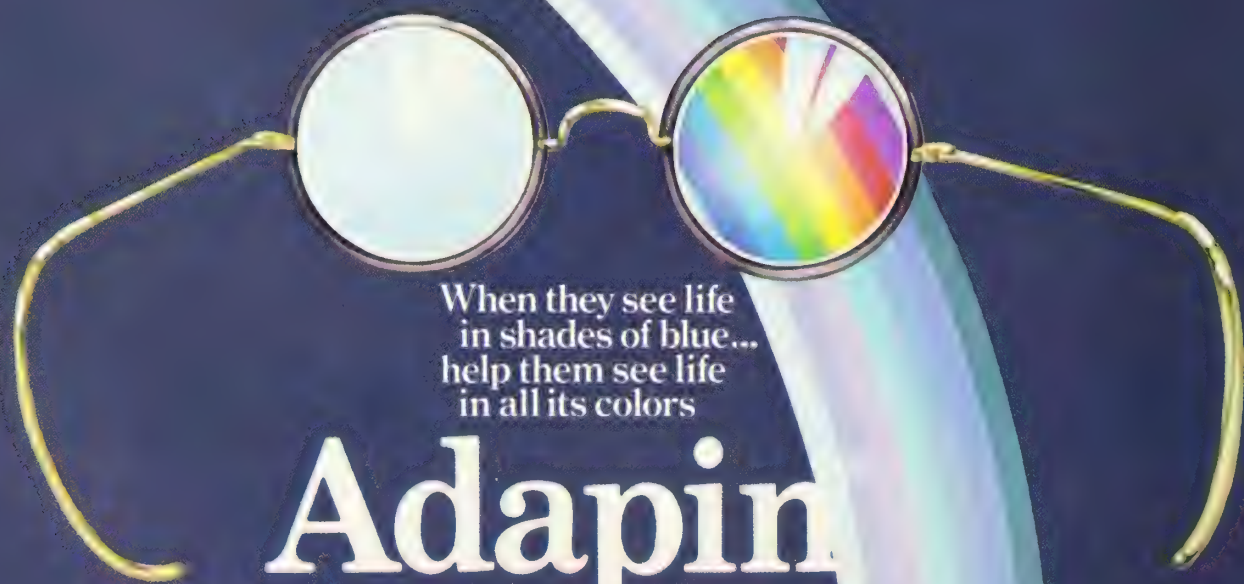
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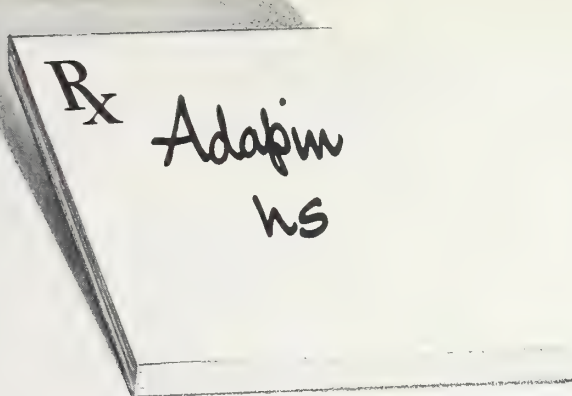
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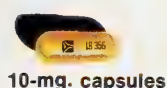
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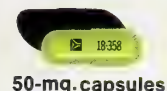
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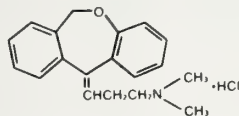
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DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin- $\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin**.

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin (doxepin hydrochloride)**, gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin**. The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin**; therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression:

10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

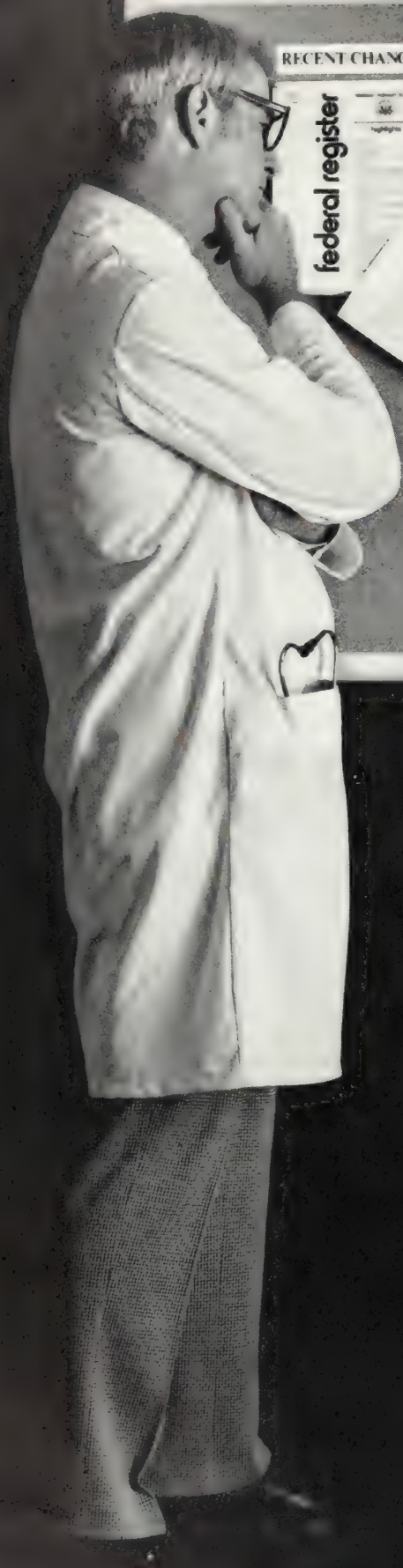
Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride, 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357), and 50 mg. (NDC 0018-0358) capsules in bottles of 100 and 1000.



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RECENT CHANGES

federal register

Providing
Drug Information
to Physicians

Informational
Bulletin #433-76

National
Health
Insurance

special report
Malpractice
insurance:

Health care doesn't
need more red tape

Drug firms challenge
"MAC" rules

Drug
Substitution

The Common Understanding
of Health Insurance
RESEARCH

Mailgram 2

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

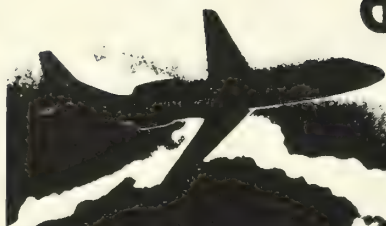
If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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FUTURE MEETINGS, SEMINARS, COURSES

Ob-Gyn Symposium at St. Louis in April

The 4th Annual Symposium on Obstetrics and Gynecology will be conducted at the Washington University School of Medicine (Wohl Auditorium) St. Louis, on April 11 and 12. The course is approved for 10 hours Category 1 credit with the AMA. Equal credit has been requested from the AAFP. For further information call collect 314-454-3873 or 314-367-9673.

Spring Programs at Lexington Announced

The University of Kentucky announces four Continuing Education programs to be held in April and May:

Apr. 15-16—Endocrinology for the Practicing Physician; registration fee \$75; at the University Medical Center, Lexington

Apr. 21-22—The Menopausal Syndrome: Physiology and Therapy; registration fee \$100; at the Hyatt Regency, Lexington

May 18-20—Symposium on Radiology of the Non-Traumatized Emergency Room Patient; registration fee \$250; at the Hyatt Regency, Lexington

May 26-27—Pediatric Chest Problems; at the Hyatt Regency, Lexington; registration fee to be determined.

For further information, write Frank R. Lemon, M.D., Continuing Education, College of Medicine, Lexington 40506.

MacKenzie Seminar on April 21

The Sixth Annual MacKenzie Seminar on "Treatment of Breast and Reproductive Tract Malignancies" will be conducted by the Department of Obstetrics and Gynecology and the Graduate Medical Center of St. Mary's Hospital, Evansville on Apr. 21, 1977, at 1 p.m.

Cancer of Breast Symposium at Chicago

The Department of Surgery of the Chicago Medical School will sponsor a symposium on "Cancer of the Breast" on Sat., Apr. 30, at the North Shore Hilton Hotel in Skokie, Ill.

Care of Children in Hospitals Subject of Michigan Symposium

The Association for the Care of Children in Hospitals will hold its Annual Conference at the Hyatt Regency Hotel, Dearborn, Mich., May 25 to 28. Subject for the meeting is "Speaking Out For Children." Registration fee for members is \$60, for non-members, \$85. Write to Mary Frances Podolak, R.N., Children's Hospital of Michigan, 2901 Beaubien Blvd., Detroit 48201.

Symposium on Common Pediatric Problems

Children's Hospital National Medical Center and George Washington University are sponsoring a three-day Symposium on Common Pediatric Problems June 8 to 10 at the Children's

Hospital, Washington, D.C. The program is approved for credit with the AMA and the American Academy of Family Physicians. For full information write to Mrs. Susan Weiss, 13407 Brackley Terrace, Silver Spring, Md 20904.

Colposcopy, Cervical Neoplasia Course

An advanced course "Colposcopy and Management of Patients with Early Cervical Neoplasia" will be conducted by the Medical College of Wisconsin on June 24 and 25 at the Marriott Inn Motel in Milwaukee. The registration fee is \$300. Write Adolf Stafl, M.D., 8700 W. Wisconsin Ave., Milwaukee 53226.

Five-Day Meeting in London On "Advances in Medicine"

"Advances in Medicine" Conference is announced for July 23 to 28 at the Wembley Conference Center in London. The five-day meeting will be divided into five programs—Genetics and Foetal Abnormalities, Cancer, Virus Diseases, Bioengineering and Rheumatology. The Royal Society of Medicine is the sponsor. Provisional program and registration data may be had by writing the Conference at 43 Charles St., Mayfair, London W1X 7PB, England.

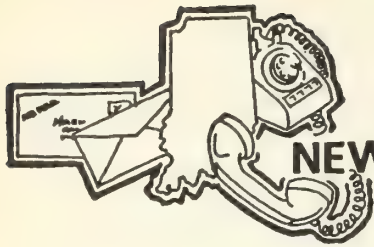


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NEWS NOTES

Medical Licensing Board Moves

The Medical Licensing Board of Indiana has moved its office to M & W Building, 700 N. High School Road, Indianapolis 46224. All practitioners are requested by the Board to notify concerning any change of address. The Board has encountered difficulty in writing to physicians because of lack of correct addresses. Actually, each holder of a medical license is responsible for its renewal, just as the holder of a driver's license must apply for renewal without any notice from the state agency involved. The Licensing Board will be aided by the computer records of the Indiana State Medical Association in maintaining up-to-date mailing addresses and will notify licensees to the best of its ability. To avoid any lapses each licensee should write the Board if the notification does not arrive in a timely fashion.

38 Honored for More Than Quarter Century of Service

Despite a blizzard and icy conditions, 85 people turned out on Jan. 26 to honor senior members of the Owen-Monroe County Medical Society. Dr. George Lewis, president, had designated the January meeting an "Honor Night" to honor all physicians in the society who had been practicing medicine for 25 years or more. After a buffet dinner of carved sirloin of beef, coq au vin and filet of sole, Dr. Lewis presented these members with certificates indicating the number of years dedicated to medicine and the community:

- For 52 years—Ben Ross
- 51 years—Raymond Borland
- 47 years—E. Bidney, Marcel Brown, now residing in Florida; Dillon Geiger, William Stangle
- 45 years—E. Fugelso
- 43 years—Hugh Ramsey
- 42 years—Neal Baxter
- 40 years—James Topolugus, Naomi Dalton
- 39 years—Herschel Smith
- 36 years—Ambrose Estes, H. R. Schell
- 35 years—T. Middleton, James Farr, R. Buckingham
- 33 years—G. Morford, B. Spencer
- 32 years—J. Sibbitt, A. Pizzo, H. Manifold, George N. Lewis, R. Fowler
- 31 years—W. C. Seagle, G. Poolitsan, C. R. McIntire
- 30 years—Walter Owens, P. W. Holtzman, J. Hammer, R. Buck
- 29 years—I. T. Rieger
- 28 years—W. Link
- 27 years—T. Rollins
- 25 years—R. Schilling, R. Rose, J. Milan, J. Creek

Dr. Jesseph Elected ABFP Director

Dr. John E. Jesseph, Indianapolis, has been elected to a full 5-year term as one of the directors of the American Board of Family Practice. The family practice board includes representatives of five other disciplines, Internal Medicine,

Surgery, Pediatrics, Obstetrics and Gynecology, and Psychiatry and Neurology. Dr. Nicholas J. Pisacano was reelected secretary. The Board now conducts an examination for recertification. The first such examination was held in October 1976. The specialty of family practice is the only one requiring recertification. Diplomates must be recertified every six years.

Hospital Medical Staffs Elect

St. Elizabeth, Lafayette—Dr. Alvin L. Eller, Flora, president and chief of staff; Dr. J. L. Kelley, president-elect; Dr. C. T. Cline, secretary-treasurer. Departmental chiefs are: Dr. Cline, chief of medicine; Dr. T. W. Hass, ob-gyn; Dr. W. M. Sholtz, anesthesia; Dr. W. Jacobson, laboratory service; Dr. K. L. Froberg, pediatrics; Dr. D. A. McEwen, radiology; Dr. G. Gutwein, surgery; Dr. C. J. Sondgerath, family practice; Dr. W. L. Knochel, emergency room; Dr. E. C. Stuntz, psychiatry; Dr. Lindley H. Wagner, medical education.

Hancock Memorial Hospital, Greenfield—Dr. R. W. Kuhn, president; Dr. J. L. Garrison, vice-president; Dr. R. A. Henn, secretary; Dr. R. A. Hass, member of executive committee.

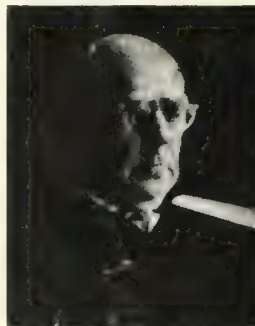
St. Joseph's Hospital, Huntingburg—Dr. Victor Borges, president; Dr. Harry Craig, vice-president; Dr. Wenceslao Magbag, secretary-treasurer; Dr. Sohrab Amini, chief of surgery; Dr. Swaroop Rai, medicine and cardiology; Dr. Taghi Hakamai, obstetrics; Dr. Rudsen Bueser, radiology; Dr. Bohdan Cymbala, pathology; Dr. J. Greg Ellison, director of respiratory therapy.

Memorial Hospital, Michigan City—Dr. Maurice Miller, president; Dr. Bienvenido Ticsay, president-elect; Dr. Algimantas J. Galinis, secretary-treasurer. Named to the executive committee are Drs. James Jensen, Gene Hay and Florian Predd, who are serving as chairmen of ob-gyn, medicine and surgery, respectively.

Symposium on Infant Nutrition Mar. 23

A Postgraduate Medical Education Program on "Infant Nutrition: A Foundation for Lasting Health" will be televised on closed-circuit in 19 cities on Wed., March 23. The program was developed and produced by Health Learning Systems under educational grants from Mead Johnson Laboratories. It is good for 34 hours of category 1 credit for Physician's Recognition Award of the AMA. A series of films and monographs, based on the televised symposium, will be available. To participate in the program contact your Mead Johnson Representative or write Health Learning Systems, 1455 Broad St., Bloomfield, N.J. 07003.

Eli Lilly Dies at 91



Eli Lilly died on January 24 at the age of 91. He was honorary chairman of the Board of Directors of Eli Lilly and Company and until very recently took an active interest in the business. Last year he participated in the firm's centennial celebration. He was born when the Eli Lilly Company was 9 years old and worked part-time when he himself was 10 years old. His association with the company spanned its phenomenal period of growth both as a business enterprise and as a research institution. Mr. Lilly's many wise and generous philanthropies are numerous and well known and include the arts, religion, education, pharmacy, medicine and civic affairs.

Deaths

Charles L. Armington, M.D.

Dr. Charles L. Armington, 72, Anderson, died Dec. 12 at St. John's Hospital.

Following his graduation from Loyola School of Medicine in 1932, Dr. Armington served his internship and residency at the Alexian Brothers Hospital, Chicago.

Active in community affairs, Dr. Armington served one term as a member of the Indiana State Fair Board.

He was a member of the Madison County Medical Society, of which he served as secretary in 1949, and the American Medical Association.

Sidney S. Aronson, M.D.

Dr. Sidney S. Aronson, 77, Indianapolis otolaryngologist, died Dec. 31 in Methodist Hospital.

He was a 1921 graduate of Indiana University School of Medicine and was an honorary member of Alpha Omega Alpha. He served in the Army in both World War I and II.

A diplomate of the American Board of Otolaryngology, he was a Fellow of the American College of Surgeons and a member of the Indiana State Medical Association's 50-Year Club. In 1970 he became a Senior Member of the Association. He was also a member of the Marion County Medical Society and the American Medical Association.

Robert W. Boswell, M.D.

Dr. Robert W. Boswell, Evansville, died Nov. 16. He was 66 and had been in general practice in Evansville since 1948.

He was a graduate of the Indiana University School of Medicine with the Class of 1944 and was elected to membership in the Lake County Medical Society in 1945. In 1948 he became a member of the Vanderburgh County Medical Society, of which he was a member at the time of his death.

He was also a member of the American Medical Association.

Robert Lee Glass, M.D.

Dr. Robert L. Glass, 76, former Indianapolis neurosurgeon and member of Indiana University School of Medicine faculty, died Nov. 9 at his home in Muncie.

A specialist in neurology and neurosurgery, Dr. Glass served as the first head of the neurosurgery department at the I.U. medical school, in addition to his private practice, from which he retired in 1958.

A Fellow of the American College of Surgeons and a member of the

American Association of Neurological Surgeons, Dr. Glass was a 1924 graduate of the University of Michigan School of Medicine. In 1963 Dr. Glass was given an honorary Doctor of Science degree from his alma mater, Earlham College.

In 1946 Dr. Glass served on the ISMA Committee on Public Policy and Legislation; he was a former member of the Marion County Medical Society and the American Medical Association.

Marvin C. Heck, M.D.

Dr. Martin Casper Heck, Jasper and Christmas Lake Village, died Dec. 19 in Memorial Hospital, Jasper. He was 68.

He received his M.D. degree from the University of Louisville Medical School in 1933. After completing his internship at St. Elizabeth Hospital, Lafayette, he moved to Jasper, where he was in practice for 40 years, with the exception of four years during which he served in the Army Medical Corps in World War II. He was stationed in Japan.

Dr. Heck was a member of the medical staff of Memorial Hospital, Jasper, and St. Mary's Hospital, Evansville, and was a member of the Dubois County Medical Society.

Cecil L. Rudesill, M.D.

Dr. Cecil Logan Rudesill, 89, Indianapolis internist, died Jan. 4 at home.

Following his graduation from the Indiana University School of Medicine in 1918, he interned at Robert W. Long Hospital. He retired in 1966.

Dr. Rudesill also served as a professor of clinical medicine at the University and he collaborated in the first clinical use of insulin on human subjects in 1922 and 1923.

A diplomate of the American Board of Internal Medicine, Dr. Rudesill was also a Fellow of the American College of Physicians and was a Senior Member of the Indiana State Medical Association. He became a member of the 50-Year Club in 1968. In addition, he was a member of the Marion County Medical Society and the American Medical Association.

Herbert C. Schlosser, M.D.

Dr. Herbert Carl Schlosser, Elkhart, died Dec. 16 at home. He was 82 and had retired from active practice in February 1973.

A 1921 graduate of Rush Medical School, Chicago, he interned at St. Anthony Hospital, Chicago and was

licensed in Indiana in 1921. He was a veteran of World War I.

In 1965 Dr. Schlosser was elected to Senior Membership and in 1971 became a member of the Indiana State Medical Association's 50-Year Club. He was also a member of the Elkhart Medical Society.

Jose A. Torrella, M.D.

Dr. Jose Alfonso Torrella, 68, died Dec. 19 in Winona Memorial Hospital, Indianapolis.

A native of Camaguey, Cuba, Dr. Torrella was in general practice in Speedway for 40 years. He was a 1935 graduate of Emory University School of Medicine and interned at St. Margaret's Hospital, Hammond, following which he was a resident in anesthesia at St. Francis Hospital, Beech Grove, for two years.

Dr. Torrella saw active duty in the European Theater of Operations during World War II.

He was a member of the Marion County Medical Society and the American Medical Association.

Patrick H. Weeks, M.D.

Dr. Patrick Henry Weeks, 89, Michigan City, died Jan. 2 at St. Anthony's Hospital.

A graduate of the Georgia Medical College in 1911, he served on the staff at Milledgeville State Hospital, Georgia, at Central State Hospital, Indianapolis, and at Warren State Hospital, Pennsylvania, before coming to serve on the staff of the Indiana State Prison at Michigan City in 1920. He was on the prison staff for 30 years. Until 1973 he was a psychiatrist for the Lake County Criminal Court and he also was on the faculty at Notre Dame University for seven years, lecturing on criminology.

Dr. Weeks was a member of the LaPorte County Medical Society and the American Medical Association. In 1959 he became a Senior Member of the Indiana State Medical Association and in 1961, a member of the 50-Year Club.

Roscoe Wildman, M.D.

Dr. Roscoe Wildman, who practiced at Peru for 48 years, died Dec. 1. He was 82.

He was graduated from the University of Cincinnati Medical School in 1926 and retired from active practice Dec. 1, 1974.

Dr. Wildman was a former member of the Miami County Medical Society and the American Medical Association.

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Letter

to the editor

To the editor:

I have just read with interest and concern the article in the November 1976 issue of your journal by M.C. Todd, M.D., concerning product selection legislation in the various states. I would like to comment on the closing paragraph of the article:

Drug substitution is not an issue that af-

fects only the pharmacist. It concerns the physician and the integrity of medical practice. As physicians, we must organize to defeat ill-advised legislative substitution schemes, and to communicate the reasons for our opposition to government, to the communications media and to the people.

Dr. Todd's observations are, in my opinion, correct and unquestioned, but they are also incomplete. The issue of drug substitution most certainly affects the pharmacist and the physician, but more importantly it affects the PATIENT, the subject

of both professions' concern. The patient, in my opinion becomes the BIG LOSER!

And concerning liability as mentioned earlier in the article. There might well be a whole new approach taken if some court or judge somewhere would hold the legislative body passing such laws liable for their eventual outcome to the patient's health.

L.A. LLOYD, R.Ph.

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PHYSICIAN OPENING IN INDIANA REHABILITATION SERVICES
INDIANA REHABILITATION SERVICES has openings for physicians in its various divisions. Interested persons should contact Dr. Walter E. Deacon, #1016 Illinois Building, 17 West Market Street, Indianapolis, Indiana, Telephone: 317-633-5961.

WANTED-PSYCHIATRIST to direct the Mental Hygiene Clinic at VA Outpatient Clinic in Evansville, IN. Beginning salary up to \$45,000 depending on qualifications. 30 days vacation, 15 days sick leave, educational opportunities and many benefits. Licensed in any State. An Equal Employment Opportunity employer. Contact Chief Medical Officer, VA Outpatient Clinic, Evansville, Indiana 47708. Telephone: (912) 423-6871.

WANT TO BUY two copies of "One Hundred Years of Indiana Medicine," by Drs. Combs and Kiser. Write or call THE JOURNAL, 317-925-7545.

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CONFERENCES for Medical Professionals—A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialties included. Send a \$10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

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NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

ered for display type advertising.

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April 1977
Vol. 70 • No. 4

OF THE INDIANA STATE
MEDICAL ASSOCIATION



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Valium (diazepam) is a benzodiazepine with a character all its own.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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MEDICAL MUSEUM NOTES



Franklin A. Bryan, M.D., director of the Fort Wayne Center for Medical Education, has a deep interest in Indiana medical history and is an enthusiastic supporter of the Museum. He recently delivered books and equipment to the Museum, gifts from Mrs. Gustav Esch of Leesburg, widow of Dr. Esch. Included with this material was a stereoscope and set of stereo cards for anatomy, and another set featuring the manifestations of syphilis.

Since receiving this material I found a three-volume set on ophthalmology at a used book sale, two volumes of which consist entirely of stereo cards. These stereo cards are marvelous teaching aids and are priceless contributions to the Museum. They have been placed in the room designated on the original plan as Anatomical and Pathological Museum. This is an appropriate location, since syphilis in its late manifestations is so rarely encountered these days that it belongs in a museum. And indeed the Pathological Museum does contain numerous brain specimens, prepared by the late Dr. Walter Bruetsch, of all the complications of central nervous system syphilis, as well as of other brain maladies. Most visitors to the Museum (more than 1,000 last year—mostly students or professionals in medical and paramedical fields) find this room the most interesting. The addition of the stereoscopic aids to medical education is a welcome one.

A recently published book, and

one which is still available (*Wonders of the Stereoscope* by John Jones, Alfred Knopf, New York, 1976) provides most of the following information about the history of the stereoscope.

The principle was first conceived by the prolific English inventor, Sir Charles Wheatstone, in the early 1830s. Although the first crude photograph was made in 1826 by Niépce, it was not until the 1840s that Daguerrotypes became well known and the photographic stereoscope appeared.

Wheatstone produced his stereo illusion of solid objects by placing two drawings of slightly different perspective in a viewing apparatus which fused the images by means of mirrors. This was a reflecting stereoscope. The subject matter was limited to line drawings of solid objects.

Following the introduction of the Daguerrotype, another Englishman, Sir David Brewster, invented the refracting stereoscope, modifications of which would ultimately become a standard part of the parlor of most enlightened households from the 1850s into the 1920s.

Most of us associate these devices with the subjects of travel and geography. Brewster appreciated the scientific value of the stereoscope, particularly for astronomy. Stereo views of the moon were taken as early as 1864, these being taken at two dif-

ferent periods of time from a single camera position, in order to achieve the necessary perspective for the stereo effect. Such views of the heavens give a three-dimensional effect with the planets standing out prominently in the foreground.

The only medical use of the stereoscope mentioned by Jones is the Edinburgh Stereoscopic Atlas of Anatomy: "In surgery the photograph does not convey the important spatial relationship between parts of the body as clearly as the three-dimensional view. In 1900 the Edinburgh Stereoscopic Atlas of Anatomy was issued for medical students: This consisted of five boxes of cards printed with anatomical notes."

The sets now owned by the Museum include (1) the Edinburgh Stereoscope Atlas of Anatomy; T. C. and E. C. Jack, Edinburgh, 34 Henrietta Street, London W.C. 1900. (2) untitled set of syphilis cards copyright 1910 by Dr. S. I. Rainforth, New York, and (3) *Diagnosics of the Fundus Oculi* by Edward L. Oatman, Troy, N.Y., the Southworth Company, 1913.

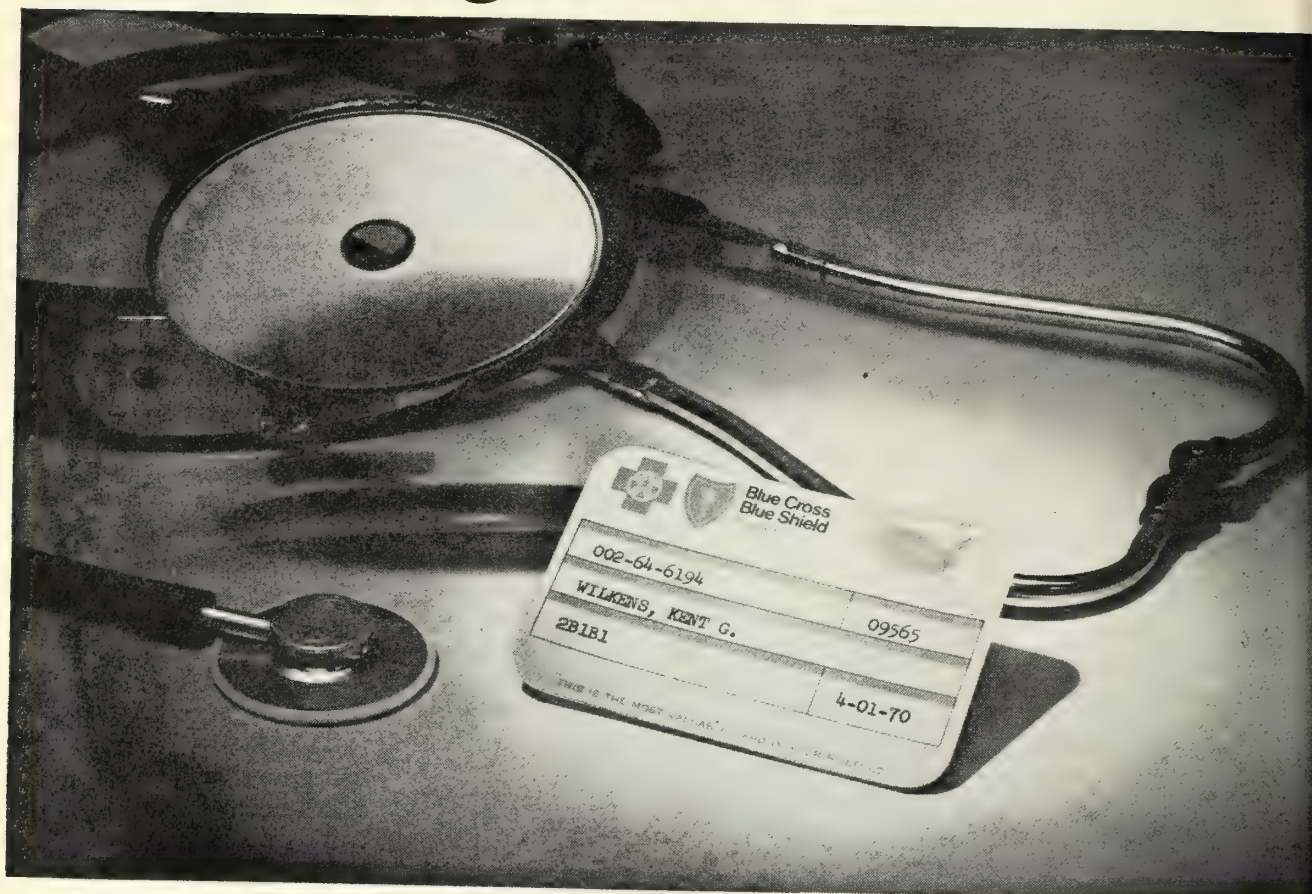
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This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

The Carter Administration has fired the first torpedo in its opening battle against escalating health care costs by asking Congress to approve a "permanent hospital cost containment system" that would cover all hospital operations, private as well as governmental.

Recommended in the revised budget prepared by the Administration is a limit of about 9% on increases in reimbursement for operating costs per admission for each hospital for the fiscal year that starts Oct. 1.

Other features of the plan "to contain the continued rapid and disturbing rise in the cost of health care" included:

- **waiver for states with acceptable hospital rate review programs.
- **separate controls on hospital outpatient departments, to encourage alternatives to inpatient care.
- **federal programs to encourage additional cost containment activities, such as second opinion before surgery, pre-admission review for non-emergency hospital care, etc.
- **monitoring for federal compliance, primarily using data already reported by hospitals for other programs, such as Medicare and Medicaid. Hospitals found in violation of reimbursement ceilings in any year could "repay" excesses by reducing charges or reimbursement increases in future years. Civil and criminal penalties would be included to combat fraud and abuse.

Under the proposal, the Health, Education, and Welfare Department Secretary would appoint a National Advisory Committee "of broad representation" to help determine future trends in spending for hospital care.

The program would be directed by the Health, Education, and Welfare Department and would begin with a directive from Congress to establish limits on annual rates of increase in hospital reimbursement from all payors, beginning in fiscal year 1978, after consultation with the health industry and the public. The program itself would be administered in large part by the hospitals and private third party payors, according to HEW.

The plan is to evolve a more permanent cost containment program later. This plan would remain in effect "until absorbed by reimbursement provisions of a comprehensive national health insurance plan."

Savings of such a program were estimated to be about \$1 billion the first year, rising to \$5.5 billion in 1981.

Asked why physician fees were not covered, the HEW Secretary said his department is taking "one step at a time."

Continued on page 170

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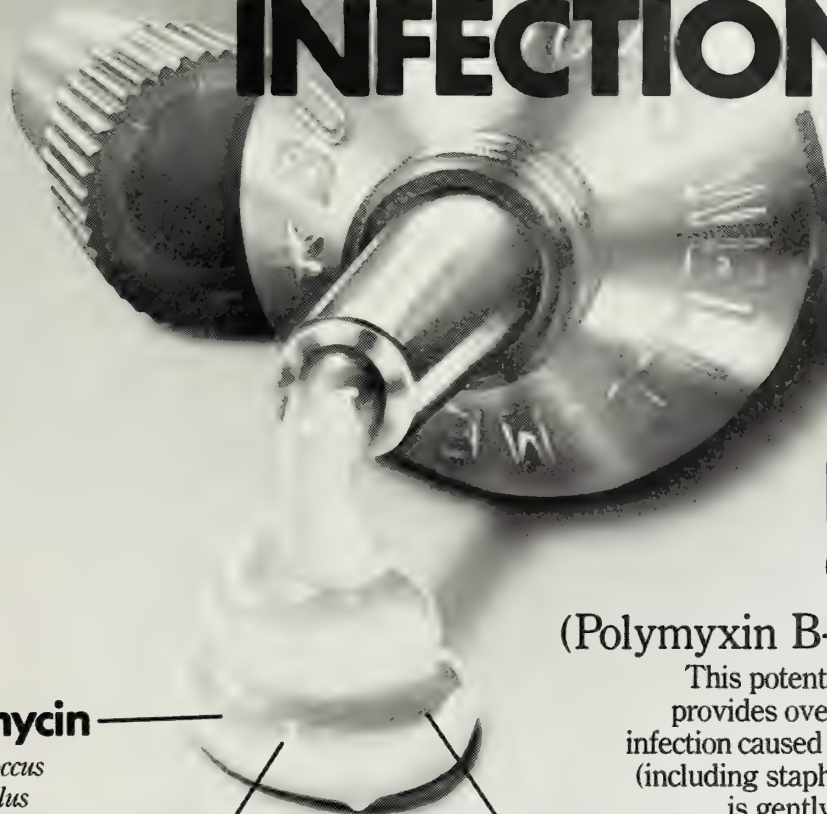
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3.	Claude J. Meyer, Jeffersonville	Charles X. McCalla, Paoli	Oct. 1-2, Clarksville
4.	Ivan T. Lindgren, Aurora	Gerald T. Bowen, Lawrenceburg	May 4, Lawrenceburg
5.	Fred Dettloff, Greencastle	Gregory Larkin, Greencastle	Greencastle
6.	Clarence C. Clarkson, Richmond	Hal Rhynearnson, Fortville	Greenfield
7.	John M. Records, Franklin	M. O. Scamahorn, Pittsboro	June 8, Greenwood
8.	Clarence M. Ashburn, Muncie	David J. Dietz, Muncie	June 8, Muncie
9.	John A. Knot, Lafayette	David L. Evans, Lafayette	June 2, Monticello
10.	James R. Brown, Valparaiso	Barron M. F. Palmer, Hammond	
11.	William Dannacher, Wabash	Fred Poehler, La Fontaine	
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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSEAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Califano said "we will be looking at that to see what should be done." There has not been enough time to move in this area with a proposal that could work and that would be fair to the people involved, he said.

The hospital cap is no cinch to clear Congress which has been leery in recent years of wage-price freeze plans and which last year refused even to consider President Ford's recommendation for caps on Medicare reimbursement increases for physicians and hospitals.

Under the plan, no hospital could increase its overall level of charges by more than the negotiated and federally sanctioned ceiling.

Clafano said that if hospitals raise charges without economic justification before the program goes into effect "it may be necessary for the legislation to have sufficiently retroactive impact to nullify the benefits of such improper conduct."

The Federation of American Hospitals called the plan "unrealistic and unfair." John A. Bradley, FAH President said "The proposal is a retread of President Nixon's Phase IV control program and it is inconsistent with President Carter's policy against wage-price controls as well as his desire to reduce the growth of government."

Bradley said an arbitrary cap on reimbursement "would be a government directive to hospitals to sacrifice the quality of care."

He added: "It is disappointing that government has not addressed the causes of hospital inflation, particularly the malpractice problem. Under an arbitrary cap, a hospital could find itself in the ludicrous position of having to restrict the number of tests a physician may order."

THE CARTER ADMINISTRATION HAS ANNOUNCED plans to write off the military medical school as a \$50 million mistake.

Defense Secretary Harold Brown said: "The University of Health Sciences is to be closed, its current students placed

elsewhere in scholarship programs and its facilities put to other use. Physician needs of the military services can be satisfied more economically over the long run by direct recruitment. The 1978 budget can be reduced by \$14 million."

The surprise decision came as the military medical school was midway through its first year of operation with 32 students and construction of a building was well along on the grounds of the Bethesda Naval Medical Center near Washington, D.C.

The school has been opposed by the American Medical Association since Congress considered the proposal in 1972. In the interim it also has come under severe attack from various study commissions and lawmakers as an inordinately expensive method of producing relatively few physicians for the armed services.

The defense announcement was part of a series of policy proposals contained in President Carter's revised budget for fiscal 1978.

THE DILEMMA FACING THE CARTER ADMINISTRATION on national health insurance was bluntly stated by the Congressional Budget Office in its annual report. A plan fully financed by taxes, as Labor proposes, would use most of the money available for new programs "and would most likely require compensating reductions in other federal programs or tax increases above current policy levels." The budget office, which helps guide and determine congressional spending and legislative plans, put the 1982 cost of such an NHI plan at a minimum of \$108 billion.

Alice Rivlin, director of the Budget Office which functions in relation to Congress much as the Office of Management and Budget functions in relation to the Executive branch, said a strong economy could leave room for new federal programs adding up to an additional \$50 billion of spending a year over the next several years. However, a wholly tax-financed NHI plan would swallow this and more, if no cost-sharing devices were featured such a plan—as urged by organized Labor—"could add from \$168 billion to \$200 billion to federal health expenditure by fiscal year 1982," said the Budget Office report. In contrast, the report continued, "a compulsory employment-based, premium-financed plan with cost-sharing (such as the AMA proposal) might increase federal spending by as little as \$15 to \$20 billion in 1982."

PRESIDENT CARTER HAS NOMINATED a Vietnam war veteran, Max Cleland, 34, to head the Veterans Administration. Cleland lost two legs and an arm from a grenade explosion in battle. In 1971 he became the youngest member of the Georgia Legislature.

The appointment was seen as a victory for the younger Vietnam veterans groups who have urged one of their own be appointed. Cleland ran unsuccessfully for Lieutenant Governor of Georgia in 1974 and then joined the staff of the U.S. Senate Veterans Affairs Committee.

THE GOVERNMENT IS MOVING ON TWO FRONTS to encourage the use of physician extenders (PEs) in rural areas.

The Social Security Administration has launched an experimental program to reimburse physicians for "independent" medical services provided Medicare beneficiaries by physician extenders. Previous policy had been to reimburse physicians for PE Medicare Part B services only those "incident to" a physician's services and performed under the direct supervision of the physician. The new policy will permit payment for the independent services of physician's assistants, nurse practitioners, medex and similar non-physician health care providers. The reimbursement will be made only to a physician ex-

Continued on page 173

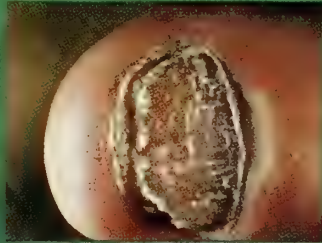


(For an introduction to "TLC," our new cartoonist, please turn to Book Reviews, page 205.)

When Griseofulvin is indicated...



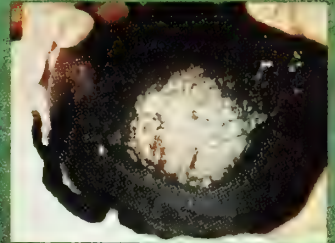
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



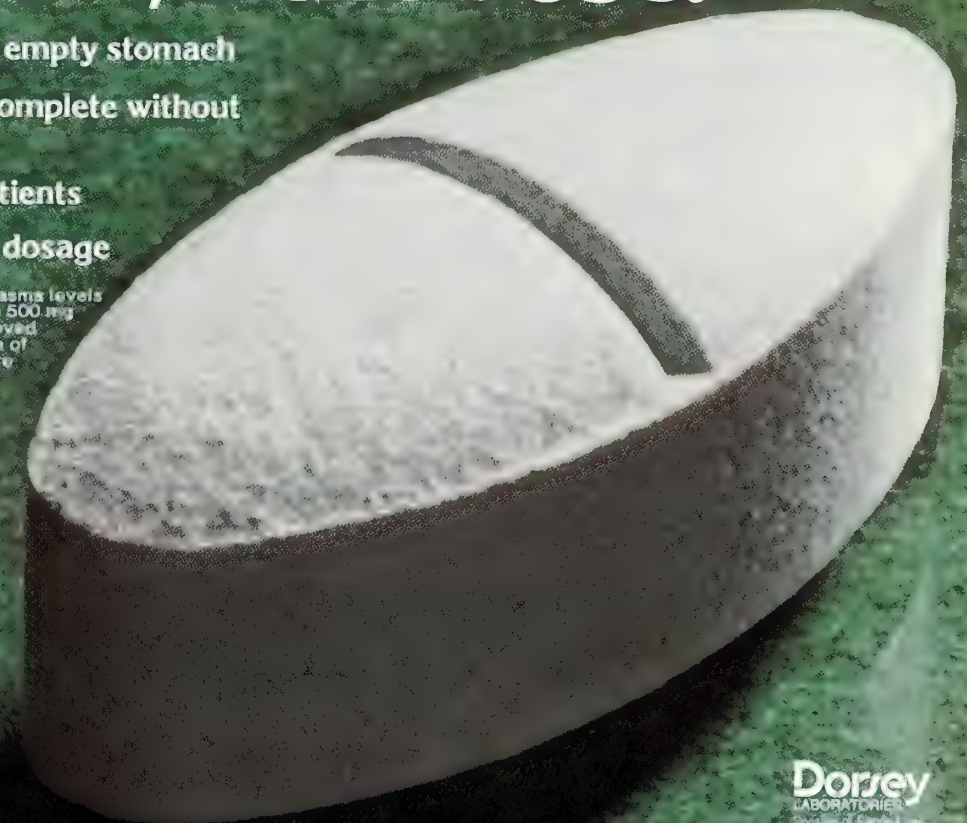
TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

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1250 mg of Gris-PEG[®] provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



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The ½ dose griseofulvin.

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Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporium*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsize griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy. Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitale
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleinii
Audouinii
Microsporium canis
Microsporium gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylnolanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6

weeks, *tinea corporis*, 2 to 4 weeks, *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months, toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsize). USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

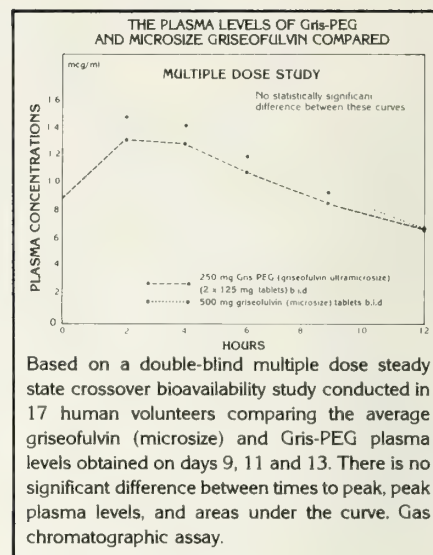
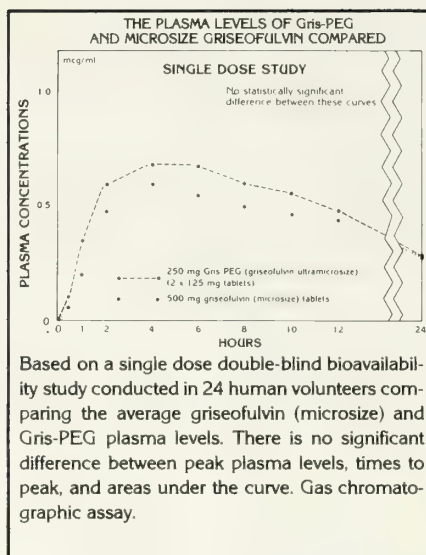
Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

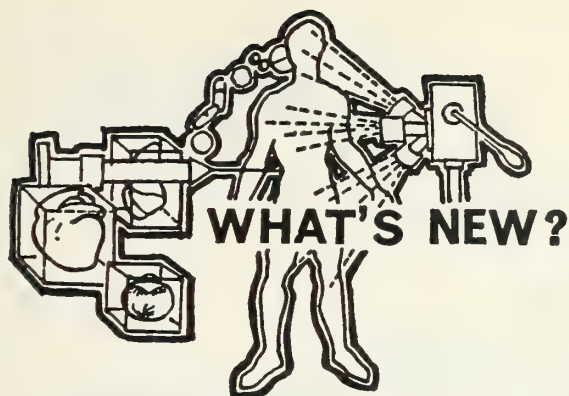
HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsize griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.



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covered with anti-static polyethylene. The manufacturer states that the cost of the Instra-Mag is less than the cost of cleaning and sterilization of reusable products.

* * *

Parke-Davis has introduced a new disposable, incontinent pad-reusable pants system, called Unigard. Composed of a polyethylene backed pad which features a new superabsorbent polymer which will hold up to 12 times its weight in fluid, plus a layer of nonwoven rayon to keep skin dry. A machine-washable snap-on pant enhances clothing and bed linen protection.

* * *

PROJECT: FILMSTRIP has a kit and instruction book to help amateurs make their own filmstrips at low cost. The Kit includes instructions, detailed examples of scripts, tools, form pads, script forms, sequence sheets, acetate cropping guide and field chart. The firm will also provide professional consultation.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

Gould has a new cardiac output computer designed for use at the bedside or in the OR. Known as the Gould Statham Model SP1425, it uses the thermodilution technic to accurately measure and display cardiac output on a digital readout. Alerts the operator if injectate volume is faulty and provides an electrical signal if the catheter itself is faulty.

* * *

Instranetics announces a new, lightweight disposable magnetic surgical drape designed to hold instruments magnetically in all locations where instruments tend to fall to the floor. It is flexible and conforms to irregular surfaces. Its name is Instra-Mag. Raised intensified magnetic elements are on a non-slip foam back and are

MONTH IN WASHINGTON

Concluded

tender's employer, not to the PE directly.

The new Social Security policy was announced shortly before Congress opened hearings on legislation with strong backing in House and Senate to require Medicare reimbursement for qualified PE programs in rural areas without the restriction of direct physician supervision. Although the four major bills up for consideration do not call for direct payment to PEs, they differ in reimbursement policies with some allowing reimbursement to rural clinics and others requiring that reimbursement be channeled only through the responsible physician.

Knotty medical ethical and policy questions will be aired at the hearings by the House Ways and Means Subcommittee on Health, with the issue of professional liability heading the list. On an even broader front, the lawmakers must consider limitations on what services can be provided by the PEs without stepping into the province of physicians. The amount of supervision and responsibility resting on the physician for the services of PEs will be a key issue. The reimbursement procedure is involved in all of these questions.

Practices that wish to be considered for enrollment in the experiment, or wish to receive further information regarding the experiment, should call collect to the University of Southern California, Division of Research in Medical Education, (Social Security contractor) at 213/221-2147 from 9 a.m. through 4 p.m., California time. All such queries must be made by May 1, 1977.

The government noted there are more than 7,000 formally trained PEs. "Whether this manpower resource continues to grow, or even continues to exist, depends in part upon federal reimbursement policies. The effect of such policy can only be magnified by the introduction of national health insurance."



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Successful treatment of malignancy, at least in the immediate future, will depend on skillful use of adjuvant therapy

Adjuvant Therapy Following Surgery in Breast Cancer

LAWRENCE H. EINHORN, M.D.

Indianapolis

BREAST cancer is the number one cause of female cancer deaths. This year there will be approximately 90,000 new cases and 35,000 deaths from breast cancer.¹ The incidence is 72/100,000 and approximately 5% of all women will eventually develop breast cancer. Despite the common occurrence of breast cancer there remains a great deal of confusion (for the patient as well as the physician) as to the preferred treatment for primary breast cancer. There has been a large volume of literature in lay publications as well as professional journals advocating less disfiguring surgical procedures, such as simple mastectomy or even "lumpectomy" followed by irradiation, as an alternative to the more traditional classical Halstead radical mastectomy, or modified radical, which spares the pectoralis muscles. There is also a great deal of debate as to whether "prophylactic" chemotherapy or radiotherapy should be employed following the definitive surgical procedure. It is the purpose

of this paper to present the results of published and unpublished studies completed through December 1975, and attempt to shed light on a confusing subject for the physician who must make these therapeutic decisions.

Survival Statistics

Before we can begin a discussion concerning adjuvant therapy in breast cancer, we must understand what the expected survival is with surgery alone. Once a patient develops recurrent disease we are dealing with a clinical situation whereby we can prolong the quality and quantity of survival with hormonal manipulation and chemotherapy but we can no longer hope to cure the patient except in ex-

tremely rare cases. Indeed, with recurrent disease, there is only a 35% two year and 10% five year survival.²

When a patient presents with a breast mass that is believed to be a carcinoma, she should have a complete history and physical examination. Prior to surgery, a PA and lateral chest x-ray, liver function studies and bone scan should be performed. Clearly, if a patient has multiple osseous metastases, any type of mastectomy is inappropriate. Also, if a patient exhibits any of the physical findings in Table 1, she is thought to be locally inoperable and we would recommend radiotherapy rather than surgery as the primary modality of treatment.

The most important factor in the prognosis of primary breast cancer is the status of the axillary lymph nodes. As can be seen from Table 2, even those patients with negative nodes have only a 78% and 65% 5- and 10-year survival. Especially dismal is the 32% and 13% 5- and 10-year survival for patients with four or more positive nodes following a modified or classical radical mastectomy. The prospects for cure for those patients are extremely dim, despite the fact the surgeon

Table 1.—Local Criteria for Inoperability

1. Extensive edema of skin over breast (peau d'orange)
2. Satellite nodules
3. Inflammatory carcinoma
4. Supraclavicular nodes
5. Edema of the arm

From the Department of Medicine, Indiana University School of Medicine, Indianapolis 46202.

Table 2.—5- and 10-year Survival Data Following Halstead Radical Mastectomy

	Number	5-yr. survival	10-yr. survival
All patients	406	63%	46%
Negative nodes	219	78%	65%
1-3 + nodes	90	62%	38%
4 or more + nodes	100	32%	13%

“got it all out.” This group of patients lends itself very nicely to adjuvant therapy, because not only is there such a dismal 5- and 10-year survival, but the probability of recurrence in the first 18 months following surgery is 50%.³

Prophylactic Oophorectomy

It has been known for many decades that many breast cancers are “hormonally dependent,” and that remissions can be achieved in premenopausal women with metastatic breast cancer by therapeutic oophorectomy. Therefore, it seemed logical to investigate the role of prophylactic surgical oophorectomy as an adjunct to radical mastectomy for the treatment of operable carcinoma of the breast in premenopausal patients. This was carried out as a randomized prospective clinical trial by the National Surgical Adjuvant Breast Project (NSABP).⁴ Three hundred fifty-seven patients were entered into this study and, following classical radical mastectomy, 154 received prophylactic oophorectomy. There was no difference whatsoever in the recurrence rate or survival for patients who were subjected to a prophylactic oophorectomy compared to the control population. Both populations were identical as to average age, node status, histology and size of primary. As a consequence of these findings, there would seem to be no further justification for the use of prophylactic oophorectomy in the treatment of operable breast carcinoma. Also, a prophylactic oophorectomy in this setting prevents the physician from being able to determine whether the patient is hormonally responsive when she develops her initial recur-

rence. In other words, if a patient has a prophylactic oophorectomy and develops recurrent disease 18 months later, a decision concerning further surgical endocrine ablative therapy (hypophysectomy or adrenalectomy) needs to be made. However, we lose the knowledge as to whether the patient responded to an oophorectomy, because if an oophorectomy is done therapeutically at a later date (instead of prophylactically), and if she fails to respond to an oophorectomy, there would be no value in further pursuing hormonal manipulation and the patient would be treated with chemotherapy.

Adjuvant Radiotherapy

Postoperative radiotherapy is by far the commonest modality of adjuvant therapy employed following radical mastectomy. Despite its commonplace practice, is there really any evidence that postoperative irradiation prolongs survival or increases the disease-free interval? There is no question that irradiation is effective for local breast cancer and can significantly lower the local recurrence rate. However, there has never been any randomized prospective study demonstrating improved survival following irradiation in any subpopulation of patients, despite the reduced incidence of local recurrences. On the contrary, several authors are beginning to question whether there may actually be a *decreased* survival following postoperative irradiation. Stjernswärd points out that of controlled clinical trials so far published, all six, including more than 3,400 patients, demonstrate decreased survival of between 1% and 10% in irradiated patients when

compared with those treated by mastectomy alone.⁵ Although it may be overly strong language to state that there is decreased survival in irradiated patients with a decrease in 5-year survival of only 1% to 10% (although this was statistically significant because of the large number), it can be clearly seen from such a large number (3,400 patients) that there is definitely and unequivocally no *increased* survival with postoperative irradiation. Stjernswärd concludes that “the routine use of postoperative radiotherapy in early breast cancer must be seriously questioned. Survival data argue against its use, despite the local effect on recurrence rates. If the routine use of prophylactic local radiotherapy following radical mastectomy were stopped, survival might increase and resources might be saved.”

Another widely quoted study evaluating the prophylactic use of postoperative irradiation is the Manchester trial, which is included in Stjernswärd's statistics. In this study,⁶ a prospective randomized trial was undertaken with both groups comparable in all parameters. A classical Halstead radical mastectomy was performed on 752 patients, and 709 had the same surgery followed by postoperative irradiation. Between 1949 and 1952 treatment was by the “quadrate” technic to treat the whole of the breast flap and the apex of the axilla in continuity with a tumor dose of 3,500 rads in three weeks at 250 kv. From 1952 to 1955, a “peripheral” technic was used, giving 3,500 rads to the apex of the axilla infraclavicular and supraclavicular fossa, and the homolateral parasternal area was also treated with 4,250 rads in three weeks. The 10-year survival for patients treated by radical mastectomy alone was 47.5% (note the almost identical 46% 10-year survival from the NSABP in Table 2), whereas the 10-year survival for radical mastectomy followed by postoperative irradiation was 44.2%. It was also of interest to note that in this study,

although there were decreased local recurrences with postoperative radiotherapy, at the time of death the percentage of patients with uncontrolled local recurrence was almost identical in both groups. The authors concluded that "irradiation doesn't prolong survival, and locally recurrent disease can be controlled when the need arises, and there is an advantage to patients in avoiding prophylactic irradiation."

The major American study trying to ascertain the role of postoperative radiotherapy in primary breast cancer was NSABP #2.⁷ In this randomized, prospective clinical trial (again alluded to in Stjernswärd's statistics and involving two identical patient populations) radiotherapy was administered to parasternal, axillary and supraclavicular fields, with a minimum of 3,500 rads in no more than three weeks or 4,500 rads in no more than five weeks. Approximately 75% received supervoltage radiotherapy, with the remainder receiving radiotherapy from orthovoltage equipment. Conclusions were derived from 1,103 patients entered onto this protocol with half the patients receiving radical mastectomy alone (control population) and the other half receiving the same surgery followed by postoperative irradiation. The 5-year survival for surgery alone was 62% and, for surgery followed by radiotherapy, 56%. Again there was a decreased incidence of local recurrences in the group receiving adjuvant radiotherapy, but at the 5-year level there was a higher incidence of distant metastases in the surgery + irradiation group (40%) than in the surgery alone group (32%). The increase in distant metastases following postoperative radiotherapy has also been demonstrated in other studies.⁹

As can be clearly seen from the results above, although local adjuvant irradiation reduces local recurrences, it does *not* increase survival. One would logically question why local radiotherapy, which definitely is effective at local destruction of breast cancer, fails to im-

prove survival. One hypothesis for this failure might be an impairment of the immune competence of the patient due to the postoperative irradiation. The importance of this competence in cancer patients was suggested by Burnet's postulate that immunological mechanisms participate in the destruction of tumor cells. Since most patients with breast cancer with pathologically positive nodes have microscopic disease remaining even after radical mastectomy, an impairment of the host's immune status by radiotherapy could account for a failure to improve survival, despite the local destruction of breast cancer by the irradiation. There have been several studies in breast cancer patients receiving postoperative radiotherapy demonstrating immunological impairment in these patients compared to those treated with surgery alone.^{9,10,11} Meyer⁹ showed significant decrease in total lymphocyte counts following postoperative radiotherapy for periods up to 10 years. It was Meyer's impression that the failure of radiotherapy to improve survival after mastectomy may be a consequence of an induced defect in cellular immunity, as reflected in the decrease of lymphocytes that negates the tumor-destructive effect of radiation. Cosimi used more sophisticated studies of cellular immunity, evaluating lymphocyte counts, delayed hypersensitivity skin tests and in vitro response of lymphocytes to phytohemagglutinin.¹¹ This study documented that local radiotherapy resulted in substantial immediate immunosuppression that, according to the authors, "could have a deleterious effect on patients with tumor outside the field of treatment since the decreased immunocompetence might permit more rapid growth of those foci."

Adjuvant Chemotherapy

Adjuvant chemotherapy was evaluated by the NSABP³ in a randomized prospective trial using Thio-Tepa that started in 1957. At this time there was concern that the finding of malignant cells in the peripheral smear of mastectomy pa-

tients shortly after surgery implied dissemination due to surgical manipulation, and thus Thio-Tepa was given in a dosage 0.4 mg/kg the day of surgery and 0.2 mg/kg on each of two days after a conventional radical mastectomy. Not surprisingly, overall, there was no improvement in the group receiving adjuvant Thio-Tepa, although the subpopulation of premenopausal patients with greater than four positive nodes did have a superior survival. Our level of chemotherapeutic sophistication has significantly increased since this early trial, and we now realize that chemotherapy for metastatic disease or in an adjuvant setting must be given for a prolonged period of time, in order to attain maximal tumor cell kill and significant prolongation of survival.

However, the rationale for adjuvant chemotherapy in breast cancer is clearly present, especially in those patients with four or more positive nodes. As mentioned previously, once a patient develops metastatic disease, she is probably no longer curable.² In order to consider adjuvant chemotherapy, we must have a patient in a high-risk category and we must have evidence of activity of the adjuvant chemotherapeutic agent(s) in metastatic disease. Equally important in the understanding of the philosophy of adjuvant chemotherapy is the realization by both the patient and the physician that the stakes are very high—disease-free survival vs. probable recurrence and death, and, despite the fact that the patient is asymptomatic and grossly disease-free, she must be willing to accept the temporary inconvenience, discomfort, alopecia and risks of chemotherapy in this setting.

The most widely publicized adjuvant chemotherapeutic trial involves the use of L-PAM (Alkeran), an alkylating agent that is presently being taken by Mrs. Gerald Ford.¹² Actually, this agent represents a compromise in the above philosophy for adjuvant chemotherapy.

Although this agent has only a 23% response rate in metastatic disease,¹³ it is relatively free of side effects, with only minimal nausea, vomiting, alopecia and myelosuppression. In other words, we realize the dismal prognosis in primary breast cancer, especially in patients with four or more positive nodes, but we are still uncertain as to how much toxicity we want an "asymptomatic, disease-free" patient to undergo. In this clinical trial, patients with positive axillary nodes were randomized following radical mastectomy to either placebo or L-PAM in a dosage of 0.15 mg/kg/day for five consecutive days every six weeks for two years. Recurrences occurred in 22% of 108 patients receiving placebo, and only 9.7% of 103 women receiving L-PAM ($p = 0.01$). For those patients at the highest risk of recurrence (four or more positive nodes), there were 21 of 61 recurrences in the placebo group and only 9 to 50 in the group given L-PAM with a median duration of follow-up of 10 months. Because of these positive results, the placebo group has been dropped, and the present study entails comparing L-PAM in this setting to more aggressive chemotherapy with Cytoxan + 5-FU + Methotrexate.

Combination chemotherapy regimens with a modified Cooper regimen consisting primarily of Cytoxan, 5-FU and Methotrexate has produced remission rates in excess of 50% in metastatic breast cancer or twice as high as that seen with L-PAM. Therefore, it would appear reasonable that this 3-drug regimen would produce results

superior to L-PAM in an adjuvant setting. In a study initiated by Bonadonna through the Milan, Italy, National Cancer Institute, patients with positive nodes following radical mastectomy were randomly allocated postoperatively to receive either no further therapy or a combination of Cytoxan 100 mg/M² p.o. days 1-14, Methotrexate 40 mg/M² I.V. day 1 and 8, and 5-FU 600 mg/M² I.V. day 1 and 8.¹⁶ Each cycle was repeated at 28-day intervals for a total of 12 courses. There were recurrences in 21 of 128 control patients and only 2 of 103 of the treated patients ($p = 0.001$); neither was a local recurrence, and no patient received postoperative irradiation on either arm. For those patients with four or more positive nodes, there were 12 of 36 recurrences in the control patients and only 1 of 33 in the treated group ($p = 0.001$). The median follow-up has been 10 months.

In the past three years at Indiana University we have been involved in treating patients with four or more positive nodes with chemoprophylaxis with Adriamycin + BCG immunotherapy or Adriamycin + Cytoxan + BCG immunotherapy. This study has been done in conjunction with Dr. Jordan Gutterman, Department of Developmental Therapeutics, M. D. Anderson Hospital and Tumor Institute in Houston, Texas. Adriamycin + Cytoxan produces 80% remissions in metastatic disease¹⁷ and is, therefore, believed by the author to be the optimal chemotherapeutic regimen for prophylactic therapy. Non-specific active immunotherapy

with BCG is capable of augmenting cell-mediated immune system of patients with small tumor burdens and is at least theoretically capable of stimulating increased host defenses against microscopic foci of disease. The preliminary results of these studies appear very exciting, as only 2 of the 50 patients have had recurrences, and none of these were local recurrences. The median duration of follow-up has been 12 months. Although this therapy produces significantly more nausea, vomiting and alopecia than L-PAM, I strongly believe it will also produce significantly improved disease-free periods and, I hope, survival, when compared to L-PAM. Myelosuppression has been relatively mild, and no patient has required hospitalization for any complications of therapy. There has not been any evidence of Adriamycin-induced cardiac toxicity or Cytoxan-induced hemorrhagic cystitis in these patients. Our present regimen is shown in Table 3.

Because of the very positive results with this regimen for patients with four or more positive nodes, we are now employing it for all patients with positive nodes following surgery for primary breast cancer.

The following evidence exists to support the hypothesis that adjuvant chemotherapy will not only increase the disease-free interval (as it already has) but will also significantly prolong survival in breast cancer:

1. Previous adjuvant chemotherapy trials in other responsive diseases, e.g., Ewing's sarcoma¹⁸ and embryonal rhabdomyosarcoma,¹⁹ has both increased the disease-free interval and significantly prolonged survival.
2. Chemotherapeutic agents are significantly more effective when there is a low tumor burden and a higher percentage of tumor cells undergoing proliferation.

**Table 3. — Adriamycin + Cytoxan + BCG —
Chemoprophylaxis**

Adriamycin 40 mg/M² IV
Cytoxan 600 mg/M² IV ————— q 4 weeks

BCG by scarification 1, 2 and 3 weeks after above chemotherapy

Adriamycin stopped at total dosage of 280 mg/M²; then chemotherapy continued for a total of two years with Cytoxan + Methotrexate + 5-FU

3. A one- or two-log reduction in tumor burden in an adjuvant setting may cause enough tumor reduction to allow the host to regain immunological control over his tumor.

4. Data from the Lewis Lung system, an animal model for slow-growing solid tumors such as breast cancer, reveal that 10^6 tumor cells injected I.V. will kill most animals by day 25; if Cytosar is given on day 14, which is roughly one day before the animals begin to die, a slight prolongation in survival occurs. This same chemotherapy, however, when administered on day 2 or day 6 (before macroscopic disease appeared) resulted in 100% cures.²⁰

Summary and Conclusions

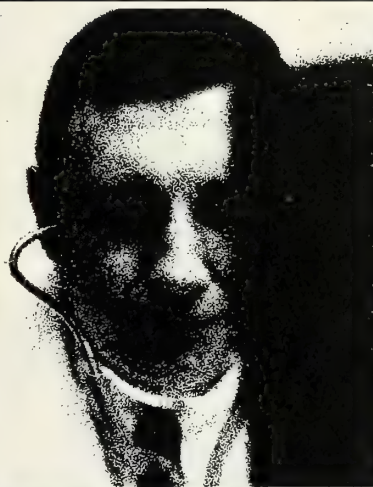
Although there continues to be a

raging debate concerning the optimal surgical or surgical + radiotherapeutic procedure for primary breast cancer, we feel that at the present time all patients must receive a radical or modified radical mastectomy so we can properly stage them and determine their eligibility for prophylactic chemotherapy or chemoimmunotherapy. Since the standard therapy, that is, radical mastectomy alone, produces results which are less than acceptable, greater emphasis must be directed toward systemic therapy to achieve gains relative to attaining a higher 5- and 10-year survival rate. Then, and only then, can we reinvestigate improving cosmesis with lesser surgical procedures.

Despite its widespread use, postoperative radiotherapy does not prolong survival and I believe it has no place in the management of

postoperative patients who receive adjuvant chemotherapy, because, thus far, local recurrences have been exceedingly rare with effective adjuvant chemotherapy. The optimal adjuvant chemotherapeutic regimen and the role of immunoprophylaxis remains to be established. I also believe that once the prolonged disease-free periods achieved with effective adjuvant chemotherapy are translated into significantly improved 5- and 10-year survivals, all patients, including those with negative nodes, should receive adjuvant chemotherapy, for even this most favorable group has only a 78% 5-year survival. ◀

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Duodenal Barium Aggregates from Carcinoma of the Pancreas

RUSSELL E. WIGH, M.D.
Augusta, Ga.

L. JANE McDOWELL, M.D.
Indianapolis

RECENT epidemiological analysis indicates that the incidence of carcinoma of the pancreas is increasing, that the prognosis remains poor and that the five-year survival rate is but 2%.¹

In 1961 Salik² considered that a preoperative diagnosis might be made correctly in 75% to 85% of patients with carcinoma of the head of the pancreas by conventional radiological methods, but few of us

have attained this skill.

Both texts^{3,4,5,6,7,8} and articles^{2,9,10,11,12,13,14,15} help us by listing signs for which one should search. Some of these signs relate to alterations in the mucosal pattern. Ulceration has been discussed as an infrequent sign.⁸

One of the hindrances in attempting to define early roentgen signs of this cancer is the absence of opportunities for surgical tissue correlation. Only one of our patients had pancreatico-duodenectomy. Perez, Powers, Holtz and Spjut,¹⁵ for their correlative roentgenologic-pathologic report covering almost 20 years

(1943-1962), found only 12 patients with carcinoma of the head of the pancreas who had a one-stage Whipple procedure.

It may well be that what will be described as a barium aggregate could be a very superficial slough (ulcer) or be due to a neuromuscular change deep to the mucosa. There is no intent to deprecate a search for thick or flat or distorted folds. However, radiologists are so used to a search for barium collections, either in the duodenal bulb or stomach, that possibly a change in visual orientation to one of greater familiarity will be found to be helpful.

Thirty-eight cases of carcinoma of the head of the pancreas were reviewed. Only 26 had upper gastro-

From the Department of Radiology, Indiana University School of Medicine, Indianapolis 46202.

Reprint requests to Dr. Wigh at the Department of Radiology, Medical College of Georgia, Augusta 30902.



FIGURE 1

A large ulcer crater (arrows) due to sloughing of a carcinoma of the head of the pancreas invading the descending duodenum. Mass is present laterally.

The patient was jaundiced for one month prior to admission.



FIGURE 2

The pancreatic carcinoma has invaded the second and third portions of the duodenum. A triangular 2 cm slough is marked by arrows and constitutes the major remaining passage through duodenum encapsulated by neoplasm.

The patient was not jaundiced.



FIGURE 3

An ulcer is present in the proximal descending duodenum. Tumor nodules (arrows) within it veil the ulcer.

The patient was jaundiced for three weeks prior to admission.



FIGURE 4A

FIGURE 4
(A) A star-like aggregate of barium in the descending duodenum. (B) A template of (A). A small tumor nodule is present (arrow). (C) Spotfilm three weeks later. The sketch (4B) helps demonstrate constancy; the aggregate is not appreciably changed.

The patient was not jaundiced.



FIGURE 4B



FIGURE 4C

intestinal examinations available. Of these, 85% had surgical or autopsy confirmation of the disease.

In a retrospective review only three patients had a clearly defined ulcer. Two of them had explorations with positive biopsies for pancreatic carcinoma. The third patient had a typical clinical course, a positive liver biopsy and a positive celiac arteriogram.

These craters are illustrated in progressively diminishing size to contrast with the less typical barium aggregates that will be demonstrated subsequently. When very large, a sloughed portion of a pancreatic mass is readily visible (Fig. 1). Similarly, a medium sized crater representing the channel by which the barium outlines the internal aspect of an encircling tumor (Fig. 2) is a familiar site elsewhere in the gut. When an ulcer, even if relatively small, is evidently poorly or irregularly filled because of contained mass, one's experience again

is sufficient to guide him correctly (Fig. 3).

Our purpose is to describe aggregations of barium less familiar in appearance, and usually smaller in size, which occur because of carcinoma of the head of the pancreas. We define the duodenal aggregate as a persistent collection of barium,

regardless of its shape, except that it is flat. The form is generally star-shaped to triangular or linear. The star is a product of the pooled barium in approximate continuity with barium between folds. Perhaps some of them are areas from which only the mucosa has been denuded by the underlying external neoplasm; however, we have evidence that this is not the cause in all instances.

Eleven patients had such findings in the descending portion of the duodenum. Five of these had cholecysto-jejunostomy with positive microscopy. One had a liver biopsy consistent with pancreatic adenocarcinoma. One patient had a positive liver scan and malignant cells in the peritoneal fluid. In the remaining four patients there was opportunity to inspect the duodenum grossly and microscopically. Three of these had an autopsy performed and one had a Whipple procedure. The epithelial covering of the descending duodenum was intact in all four.



FIGURE 5A



FIGURE 5B

FIGURE 5
(A) An aggregate of barium is present in the mid-descending limb, AP roentgenogram. (B) Utilizing the appearance of the pooled barium visible in (A), the abnormal star-shaped collection (arrowheads) can be perceived even though evacuation of the bolus is incomplete and despite a slight change in appearance due to obliquity of the projection. (C) Overdistension conceals the lesion.

The patient was jaundiced for two weeks prior to admission.



FIGURE 5C



FIGURE 6

A slit-like or linear aggregate (arrows) measuring 3 mm in width and 3 cm in length along the very medial wall of the distal descending duodenum. The folds along its immediate lateral margin are obliterated. Just lateral to this 6 mm space normal folds are seen.

The patient was jaundiced for two weeks prior to admission.

The search for such puddles of barium may require that one makes a mental template of the design of the aggregate to demonstrate its constancy. Figure 4A represents such a collection of the contrast agent and figure 4B is an artist's drawing (template) of it. However, a simple sketch could be used to identify

constancy of the barium collection on seven other roentgenograms from the same examination, with a modest allowance for positional changes. Indeed, it can be superimposed over the affected area on an examination performed three weeks later (Fig. 4C).

Figure 5A demonstrates that the aggregate stands out readily when peristalsis has moved the bolus onward so that the membrane is but lightly coated. This produces the ideal roentgenogram. If one finds this alteration from the anticipated normal membrane pattern and keeps it in mind, it sometimes can be rediscovered through greater amounts of barium (Fig. 5B). When barium fully distends the loop, as in figure 5C, the sign is obliterated.

The collection of contrast agent may be slit-like. Possibly this is simply barium caught between folds that others would call thick and elongated. Nevertheless, the slit illustrated in figure 6 was constant and reproduced on six roentgenograms.

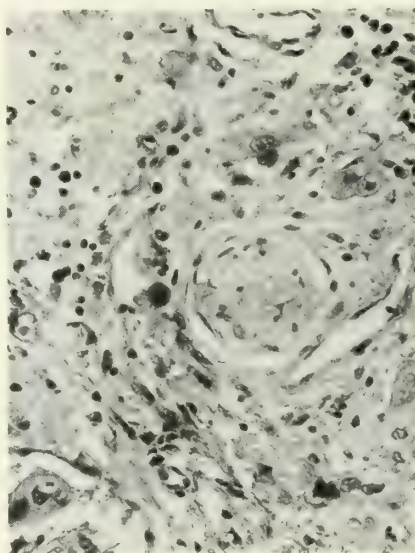


FIGURE 8A

(A) An elongated but flat aggregate of barium in the mid-descending duodenum. (B) Perineural cancer infiltration, myenteric plexus. H. and E. 400X. (C) Neoplastic infiltration of muscularis with destruction of latter. H. and E. 250X.

The patient was jaundiced for eight days prior to admission. The photomicrographs are from a pancreaticoduodenectomy specimen. The mucosa, not illustrated, was intact. Hypotonic duodenography was normal.

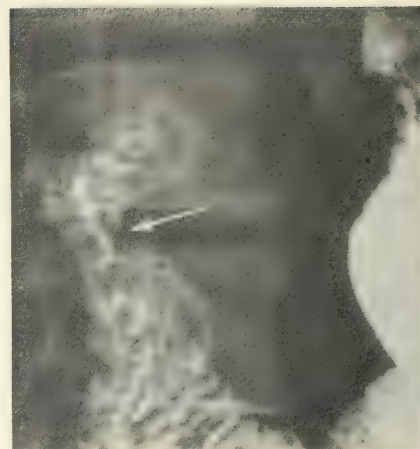


FIGURE 7

An aggregate shaped like a slit (arrow), measuring 2 mm by 12 mm. Identification of this linear barium collection enhances the search for tumor nodules in its immediate vicinity. These invaded "folds" are up to four times the thickness of those cephalad to the neoplastic area.

The patient was jaundiced for eight weeks prior to admission.

In figure 7, one notes another such linear abnormality. An analysis of the membrane about it reveals small nodules of tumor (?) that thicken the folds but only those portions in the immediate vicinity of the barium-filled slit. (Refer to figure 4 also for comparable short segments of thick folds). Considering the long sweep of the duodenum, abnormal folds are more easily identified when they are pinpointed by the aggregated contrast agent.



FIGURE 8A

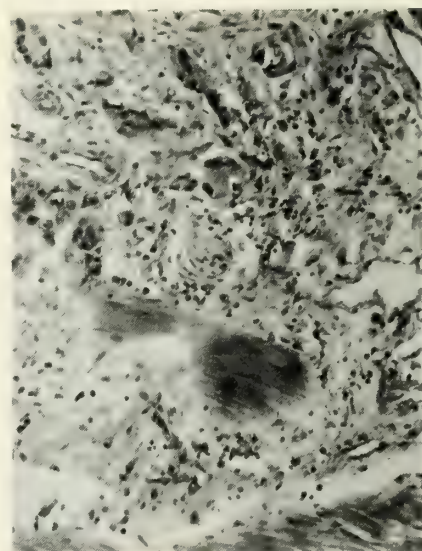


FIGURE 8C

FIGURE 9

(A) A triangular aggregate in the proximal portion of the descending duodenum, with normal folds running to it laterally. (B) Hypotonic duodenography does not demonstrate the pool of barium. The air outlines a mound similar in size and shape to the inner contour of the aggregate in (A). The patient was jaundiced for two and one-half weeks prior to admission.



FIGURE 9A

Figures 8A, B and C are of the patient who had a pancreaticoduodenectomy performed and they illustrate the barium aggregate, perineural invasion and muscle destruction. The mucosa (not illustrated) was intact. A hypotonic duodenogram was normal.

There was one other instance in which hypotonic duodenography was performed. A triangular pool of barium was evident on the conventional examination (Fig. 9A). It was not perceptible on the hypotonic examination although a small mass was suggested (Fig. 9B).

A review of a similar number of upper gastrointestinal examinations performed for problems unrelated to the pancreas indicated only one instance in which a comparable mucosal change was found. This was a post-bulbar ulcer secondary to cortisone therapy. Also, the roentgenograms of 17 cases of acute and chronic pancreatitis were reappraised. No similar and *constant* mucosal alteration was found.

Discussion

We are chided by physiologists¹⁶ for too little concern with asking questions about the regulation of

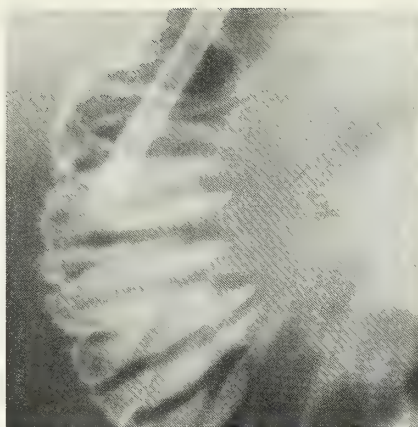


FIGURE 9B

the movement of the gut.

One of the principal functions of the small intestine is to move forward the chyme received from the stomach. An important mechanism for this transmission is the movement of the villi. This mechanism is believed to be regulated by the submucous plexus of Meisner.¹⁷ This plexus is derived from the myenteric plexus of Auerbach, which regulates the movement of the circular and longitudinal layers of the muscularis externa.

It may be deduced that in the four patients with a normal epithelium covering the aggregates of barium were due to a local hypotonia. Such limited hypotonia can be expected to be concealed by drug-induced total duodenal paralysis. Other local pathophysiological alterations elsewhere in the gut secondary to paraintestinal cancer have been observed and reported previously by Wigh and Tapley¹⁸ in instances where the mucous membrane was unaffected.

The fact that the epithelium is undisturbed makes it unlikely that in such instances duodenoscopy will be a helpful adjunct in confirming the presence of pancreatic carcinoma, although it certainly should be employed. None of these patients had duodenoscopy.

Summary

Star-shaped to triangular or, indeed, linear aggregates of barium, as well as very evident ulcers, were found in the duodenum in 14 of 26

patients with carcinoma of the head of the pancreas. Three are considered definitely to be ulcerations of the duodenal apex of the cancer. The 11 other barium collections do not have the depth of conventional ulcers and are grouped together by the designation "barium aggregate." The mechanism for this stasis is discussed.

A search for such persistent pools of barium is recommended. The concept of seeking areas filled with the contrast agent, which can be reproduced practically constantly on mucosal studies of the duodenum, may be more helpful than a consideration of fold appearances only. Presently our visual orientation is in this direction.

In a prospective examination one would advocate that in questionable cases a conventional examination be repeated with the isolated perspective to examine just the duodenum as is the perspective in hypotonic duodenography; and that adequate films of the almost completely evacuated duodenum be obtained. The constancy of an atypical, flat, ulcer-like collection of barium, particularly if reproduced at a second examination, is considered to be a highly reliable sign of carcinoma of the pancreas, even in the absence of other roentgen findings. One may caution that such evidence, if present on a conventional examination, should not be discarded if hypotonic duodenography is seemingly normal.

ACKNOWLEDGEMENTS

The authors wish to express their appreciation to Dr. Walter C. Beck for reviewing the surgical specimen, as well as for aid in preparation of the photomicrographs, and to Dr. Robert J. Peace for reviewing the autopsy cases.

Department of Radiology
Medical College of Georgia
Augusta, GA 30902

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RECENT CHANGES

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
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For rarely are sons similar to their fathers; most are worse, and a few are better than their fathers.

—Homer; *The Iliad*, Bk. XXIV

William Henry Wishard (1816-1913)

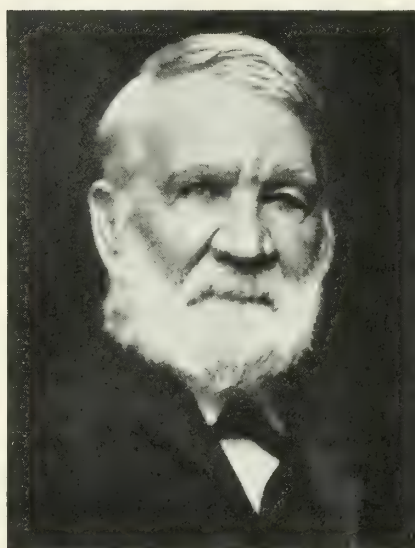
The Urologist's Father or A Physician of the Old School

RODNEY A. MANNION, M.D.
LaPorte

EXTRAORDINARY are the accomplishments of William Niles Wishard, Sr., of Indianapolis, the pioneer urologist, second president of the American Urological Association and the man for whom Indianapolis General Hospital has recently been named, yet the purpose of this essay is to trace the life and times of his father, who preceded him in service to the medical profession, and his patients.

My personal interest in William Henry Wishard stems partly from the fact that he received his M.D. from the Indiana Medical College at LaPorte in 1849 and my own urologic practice is in LaPorte. Also, I have, through research into his professional life, become convinced that he was a unique and good man. It is fitting that some knowledge of this medical progenitor should continue to be promulgated in our own age. A corollary that arises in tracing the life of William Henry is the realization that a remarkably short span of time encompassed the land-clearing stage of American population of the Northwest territory and the staid Victorian civilization that was perhaps epitomized by the life of William Niles Wishard, Sr.

The father, William Henry Wishard, was born in Kentucky in 1816 and his family left for the non-slave state of Indiana in 1825, settling 10 miles south of Indianapolis in a forested area which was infested each autumn with malaria from the swamps of the White River. By 1879, just 54 years later, his son was elected superintendent of the Indianapolis City Hospital, a



William Henry Wishard
1816-1913

post he retained for five years.

The Wishards were making a name in those days, both father and son, because William Henry had been elected coroner of Marion County in the campaign of 1876 and held office until 1884. He had originally set up practice in Greenwood but spent 13 years after 1864 in practice at Southport and his election to coroner permitted a fortuitous change to the larger city of Indianapolis, where the children could obtain better educational opportunities.

His medical education began in 1838 when he entered the office of Benjamin S. Noble of Greenwood. Dr. Noble's brother had been governor of Indiana. He used Dr. Noble's books, which were few, and he purchased a "Practice of Medicine," "Materia Medica" and "Dis-

eases of Children." In order to secure skeletons for anatomical study, he resurrected the bodies of an Indian couple who had died violent deaths after imbibing, as he says "fire water . . . to the full extent of their capacity . . . (Later) accompanied by a friend, and equipped with two sacks and a spade, I . . . soon had two skeletons in a reasonable good state of preservation." However, he was almost indicted at the next session of the grand jury in Johnson County "for bringing about a premature resurrection of two Indians . . . (but) there was an insurmountable obstacle . . . as the names of the resurrected Indians could not be obtained." So he was let off on a technicality.

After two years of apprenticeship, he was given a junior partnership and eventually relocated in family practice in Southport. Unlike many of the physicians of those early years, he tried to get any formal education that was available and took the four-month series of courses at the Medical College of Ohio at Cincinnati in 1845. Again, he matriculated at the Indiana Medical College at LaPorte for the 1848-1849 term. The requirements for graduation then were successful completion of two courses of lectures, citizenship, good moral character and a thesis. Dr. Wishard fulfilled these requisites and was duly graduated M.D. on Feb. 22, 1849. He was 33 years old—not a callow youth by any measure. Actually, it was the same year that he and 83 other Indiana physicians

founded the Indiana Medical Association—an organization of which he would be the oldest living founder after the turn of the century.

It's difficult today to realize the travail which parents endured in the days when childhood diseases pursued a frequently lethal course. Altogether, the Wishards had eight children but the first four died before the age of five. The story is told of little Agnes who walked a half mile at 2 a.m. to a neighbor to bring help to her mother who was suddenly taken ill. The child herself died shortly thereafter, as did so many. When Wishard was in school at LaPorte he wrote back to his wife at Indianapolis and to their child Mary. Again, that child was taken from them. Finally, whether it was due to the progress of civilization on the northwest frontier or mere providential good luck, their last four children lived through the early years to productive adult life.

William Niles Wishard was named for his father's beloved professor at LaPorte, Judge William B. Niles. One son became a Presbyterian minister and one daughter, Elizabeth, wrote the biography of her father from which much of this essay is taken.

An interesting sidelight on the morals and mores of the age comes through in an address which Wishard made to the Indiana State Medical Society (Association) on the occasion of his presidency of that organization on May 1, 1889. He said:

The good old dame of olden times would point you to her 10 or a dozen promising sons and daughters, the pride of her heart and the hope of her old age. We now have presented to us too often, one son or daughter with a poodle dog . . . Gentleman, you know what I mean. . . .

In the same address he advocated judicious use of bleeding but decried general spilling of blood therapeutically. He said:

It was not unusual for many persons to be bled every spring (referring to the early 1800s in Indiana). They had the superstitious belief that their blood was too thick, and that the old blood had to be drawn off to give room for a new and better article.



William Niles Wishard, Sr.
1851-1941

But he also said:

Blood letting was an indispensable remedial agent, and when wisely used by an intelligent physician was a power for good and saved many valuable lives. . . . In the first stages of pleurisy and pneumonia it was the sheet anchor. . . .

It is ironic that the early physicians had practically nothing of real pharmaceutical value but quinine with which to treat their feverish patients and they were highly revered, while the physician of today can do so much and perhaps is held in ill repute. But in the 1800s good health was apparently not thought of as a "right" but as a "gift" from a Beneficent Providence. Who is to say they were wrong? Perhaps even now the microbes are regrouping their forces and all our vaunted antibiotics and vaccinations will be impotent. It is said today that mankind has conquered smallpox, but only time will prove that contention. It is a fact that when the population was afflicted with these scourges and the doctors could only console, the doctor was well loved. A paradox of human behavior.

Wishard was overage when Governor Morton of Indiana asked him to take a commission in the Union Army in 1862. However, he volunteered to accompany the Indiana regiments as a civilian doctor and was at Vicksburg when it capitulated to "Unconditional Surrender" Grant. He was within earshot when

Grant received first word that the Confederates would surrender. Thereafter, Wishard was instrumental in having the Indiana wounded returned up the Mississippi to their homes, rather than mouldering in Army hospitals and cantonments. His stand in this controversial matter of transporting wounded home was finally affirmed by President Lincoln himself. After the Union troops occupied Vicksburg, a Confederate soldier said to Wishard "I want to shake the hand of a man who bears a charmed life." As a surgeon dressed in white he went to the regimental hospital each morning and presented a good target. Wishard said "That explains why I have heard so many bullets whizzing past my ears." He captained a riverboat of wounded back to the Ohio River and then resumed his practice at home.

His son, William Niles Wishard, Sr., was superintendent of the Indianapolis City Hospital from June 1879 to January 1886 and presided at the advancement of that institution from an asylum for destitute and dying poor to a modern hospital with all the appurtenances appropriate for the 1880s.

When Will (as his sister-biographer calls him) decided, after seeing the ravages of urological disease in the denizens of the City Hospital, to specialize in genitourinary diseases, his father opposed it. But the son persisted and became the premier urologist of the Midwest. The story of his long and fruitful leadership in his chosen specialty is another story altogether.* An anecdotal aside which Dr. Frank Bicknell of Detroit relates today is that Will Wishard said the populace of Indianapolis called him a "gent's urinary surgeon" when he first set up as a genitourinary surgeon.

How did the early specialists convince their peers that they could do

*He was the first to do prostatectomy through a combined abdominal and perineal incision in 1891 and described his use of the cautery on the prostate and bladder through a perineal incision in 1892.

the job better? It must be remembered that they blazed the trail which all of us so easily follow today.

However, returning to Will's father—the senior Wishard was well educated for his time and, along with lectures at Cincinnati and LaPorte, he went back to the former school in 1851. He gave a chloroform anesthetic at that time.

This agent was used in LaPorte and is reported as early as 1847 in the *LaPorte County Whig*. It was new to Indianapolis and the family of a young man with a dislocated shoulder was against its use. However, Wishard prevailed by asking the patient, who was of age, if he would consent. When regaining consciousness he was loud and agitated. The crowd said he "had taken leave of his senses" but he shortly gave a testimonial in favor of the anesthetic.

The old timers in medicine didn't lack courage—there were few malpractice suits but then there could be instant retribution. It seems that tar and feathers have gone out of fashion and it is just as well. There was a violent group of people outside the surgery of Ephraim McDowell of Danville, Ky., when he performed the first successful ovariectomy in 1826. Would knowledge

He was a man: take him for all and all, I shall not look upon his like again.—Hamlet.

of these primeval conditions make our modern malpractice insurance payments an easier pill to swallow?

Once Wishard was called to see a child with severe facial cutaneous infections which the mother was covering with goose grease. She persisted in spite of the doctor's adjuration against such treatment. Finally, he asked her if the grease was from a goose or a gander and at what time of the month the bird was killed. She had no idea, of course, and Wishard contended that the medicament was, therefore, ineffectual and prescribed periodic cleansing of the child's face. The healing was then satisfactory. This incident epitomizes the superstitious barriers which impeded good medical care in the old days.

And so, after 60 years in practice, William Henry Wishard died on Dec. 9, 1913. Shortly afterward millions were to die in the trenches in France and elsewhere during the Great War. The world which he knew with its simple rules and aspirations was to be no more. A copy

of the privately printed biography of William Henry Wishard is in the possession of the Indiana State Medical Association. On the flyleaf Will, his son, has written:

"The man I knew best and the best man I knew"—dated October 10, 1936. On this note the story of the pioneer physician can end.

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age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use.

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hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks.

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Treatment of Diabetic Ketoacidosis

FRANK VINICOR, M.D.
Indianapolis

OVER the past few years several new concepts in the understanding of a patient with diabetic ketoacidosis (DKA) have evolved which deserve comment because of their direct relevance to the management of this condition. Let us assume we are confronted by a patient with (a) hyperglycemia and glycosuria (i.e., diabetes mellitus), who also has (b) ketonemia and ketonuria (i.e., diabetic ketosis) and (c) displays Kussmaul respiration (i.e., diabetic ketoacidosis). Other laboratory results, including plasma glucose, electrolytes, arterial blood gases and tests of renal functions, are required to both confirm the diagnosis and establish the degree of metabolic derangements which exist in this patient. Before all these results return from the laboratory, however, some form of therapy for DKA should be instituted reasonably quickly.

There are three basic principles in approaching the treatment of a patient with diabetic ketoacidosis (Table 1): (1) Supply the missing

Table 1
TREATMENT OF D.K.A.: PRINCIPLES

1. Supply Missing Defect
2. Replace Deficits
3. Identify Precipitating Events

defect—insulin; (2) Replace what the patient has lost (i.e., deficits)—fluid and electrolytes; and (3) Identify the event which precipitated this episode of diabetic ketoacidosis. During the remainder of this discussion we will talk about these three principles, concluding with the most important one—the precipitating event.

In terms of “defects” and “deficits,” these can be classified into four main major groups (Table 2): Insulin, Fluids, Electrolytes and Acidosis. Furthermore, each of these may be discussed in terms of (a) what is known and (b) how this knowledge affects our management of diabetic ketoacidosis. In

Table 2
INSULIN
FLUIDS
ELECTROLYTES
ACIDOSIS

other words, what do we understand about diabetic ketoacidosis?

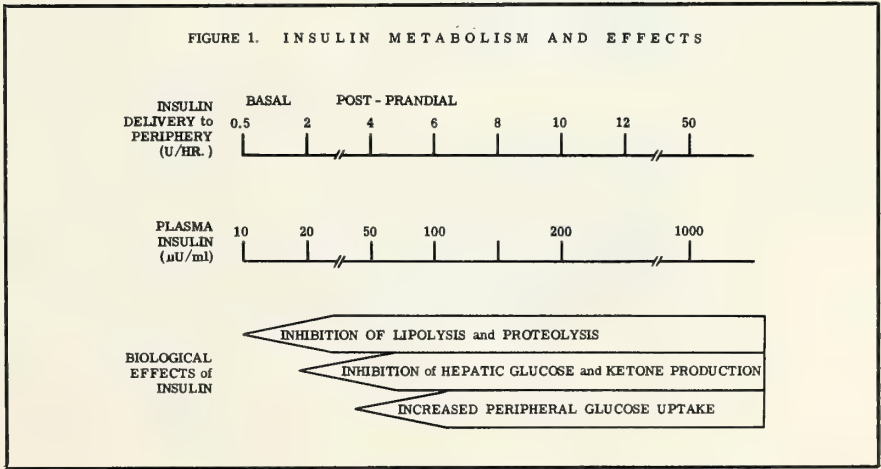
To examine the first—Insulin. This is obviously one of the most important aspects in the therapy of DKA. In Figure 1 three aspects of insulin metabolism are presented: (1) the delivery of insulin by the pancreas to the periphery (units per hour); (2) concentrations of insulin that exist in the blood stream during the basal (“fasted”) and postprandial (“fed”) state (10 to 1,000 μ units/ml); (3) a spectrum of biological effects of various concentrations of insulin. Information presented in Figure 1 suggests that insulin exerts a variety of biological effects such that low basal concen-

From the Division of Endocrinology and Metabolism, the Department of Medicine, Indiana University School of Medicine, and the Veterans Administration Hospital, Indianapolis.

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Reprint requests to Dr. Vinicor at the School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

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trations of insulin (approximately 10 μ units/ml) inhibit breakdown of fat and protein. In the postprandial state, however, more insulin is required (100 to 200 μ units/ml) in order to (a) stimulate glucose uptake by the fat and muscle cells, and (b) inhibit hepatic production of glucose. Note also that there appears to be a maximum physiologic effectiveness of insulin which seems to occur at a concentration of 100 to 200 μ units/ml and which corresponds to a delivery rate of insulin from the pancreas to the periphery of 5 to 10 units/hr. In diabetic ketoacidosis, then, our first goal is to achieve these maximum biological effects of insulin (insulin concentrations of 100 to 200 μ units/ml) *rapidly*. Furthermore, we must *sustain* this concentration of insulin—the second objective.

How can we achieve these insulin concentrations? In terms of intravenous “bolus” injections of insulin, one factor which must be considered

is the half-life of this hormone.¹ Calculations of disappearance of circulating insulin indicate that the immunological half-life of insulin is approximately eight minutes—i.e., at eight minutes following stoppage of an insulin infusion, half of the circulating insulin is gone. While the biological effect may last somewhat longer, this short half-life poses some problems, especially in sustaining maximal hormone concentrations when one is giving insulin by an intravenous bolus technique.

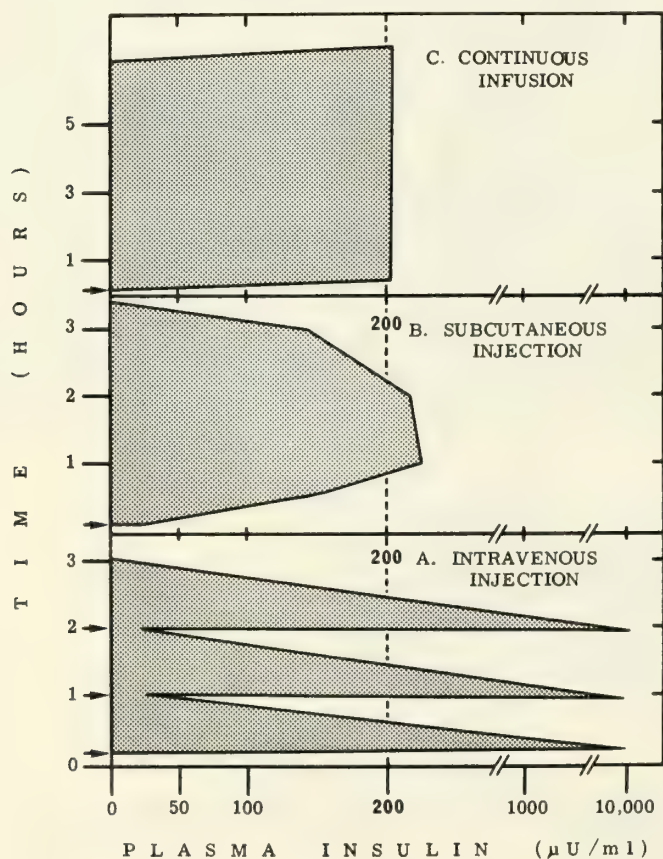
In Figure 2A the effects of 50 unit intravenous boluses of insulin are examined and plotted as insulin concentration versus time. With this method of insulin administration we certainly achieve one of our goals—insulin concentrations which insure maximum biological effects (200 μ units/ml). In fact, supernormal insulin concentrations (10,000 μ units/ml) are attained. While there is no evidence that the super-

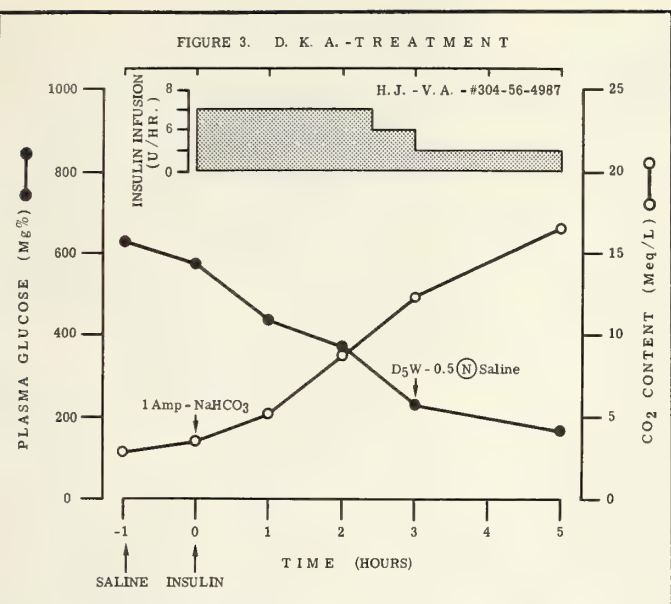
normal concentrations of insulin “drive” glucose into the cell at a faster rate than at 200 μ units/ml, potassium is forced into the cell more rapidly, thereby increasing the likelihood of subsequent hypokalemia. More important, because of insulin’s short half-life, we are incapable of achieving our second goal—*sustaining* maximal insulin concentrations. In fact, with an insulin half-life of eight minutes, intravenous injections of 50 units of insulin every 10 minutes would be required to sustain insulin concentrations of 200 μ units/ml.

In terms of subcutaneous insulin, studies of patients receiving 100 units of subcutaneous insulin are depicted in Figure 2B. With this method of insulin administration we often both exceed the desired maximum concentration of 200 μ units/ml and sustain this insulin concentration for roughly 1½ hours (the half-life of subcutaneous insulin is considerably longer than intravenous insulin). But now, the initial goal—to achieve a maximum insulin concentration quickly—has not been accomplished, and an hour’s time is required before an insulin concentration of 200 μ units/ml is attained. In Figure 2C, results of studies in subjects receiving 10-12 units of insulin/hour by constant intravenous infusion are portrayed. Both objectives of insulin administration are accomplished, i.e., maximum insulin concentrations are (a) rapidly achieved, and (b) sustained over several hours. In general, studies indicate that a patient who receives six units of insulin per hour will achieve an insulin concentration of 100 μ units/ml. But, as will be discussed later, a range of responses to insulin infusion exists and in some patients 6 units/hour will achieve insulin concentrations of only 20 μ units/ml.

Additional studies in patients with DKA receiving low-dose insulin infusions are available for analysis. The original series of articles was published in the *British Medical Journal* in 1974 and included a total of 51 patients with clearly established DKA who, in addition to receiving “traditional” fluids and

FIGURE 2. INSULIN ADMINISTRATION





electrolytes, were given insulin by constant intravenous infusion.²

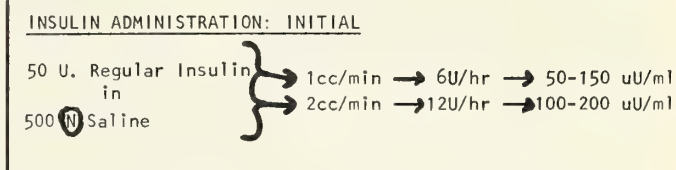
Figure 3 is an example of the effects of "low-dose insulin infusion" on plasma glucose and bicarbonate concentrations on a patient at Indiana University Medical Center. The graph basically plots changes in plasma glucose and bicarbonate concentration versus time.

There are two important points in the study. (1) Even before intravenous insulin is administered (before time 0), this patient, like the majority with DKA, has a reduction in the blood glucose concentration associated with the administration of fluids alone. The phenomenon may be due to plasma glucose dilution, improved renal clearance of carbohydrates and/or a diminished catabolic state. Whatever the reason, its observation serves to underscore the need for and importance of adequate and vigorous fluid replacement in DKA. (2) When intravenous insulin is begun, the rate of fall in blood glucose increased in this patient such that there was a reduction in glucose concentration of approximately 100 mgm% per hour. Within four hours, the blood glucose concentration had decreased by 50%. In terms of plasma bicarbonate concentrations, a reflection of ketogenesis on DKA, it is apparent that gradual correction of metabolic acidosis also occurs with insulin in-

fusion. Note, however, that the rate of improvement on acidosis is somewhat slower than the fall of plasma glucose, a point that will be discussed later.

At present there have been several studies on more than 200 patients with DKA who have been treated with low dose infusion, and I believe this technic can be considered safe and effective.³ In terms of a formula (Figure 4), one should mix 50 units of regular insulin in 500 ml of normal saline. Administering this solution at 1 ml per minute will deliver 6 units per hour, an infusion rate which should achieve an insulin concentration of 50 to 150 μ units/ml. Because of the concern that this rate of infusion may not achieve plasma insulin concentrations of 150 μ units/ml in some patients, it is probably wiser to deliver this concentration of insulin (50 units in 500 ml of saline) at 2 cc per minute. This infusion rate will achieve circulating insulin concentrations of 100 to 200 μ units/ml in almost all patients.

FIGURE 4



How does one continue an insulin infusion? (Table 3) The low-dose insulin infusion is maintained until (a) the blood glucose has fallen to 250 mg% and (b) acidosis has been corrected ($\text{pH} > 7.3$; serum bicarbonate > 20 mEq/liter). Subcutaneous intermediate insulin may then be instituted. If the blood glucose concentration decreases to 250 mg% but the patient remains acidotic (a frequent clinical situation), the insulin infusion should not be interrupted. The infusion rate should be reduced (2-4 units/hr) and the patient administered D₅W to prevent hypoglycemia. This insulin infusion is then continued until acidosis has been corrected.

If 50 units of insulin are mixed with 500 ml of normal saline, recent studies indicate that no albumin must be added to the solution to limit insulin absorption to glass and/or plastic. While some absorption will occur, it is minimal at this concentration (50 units in 500 ml) of insulin. Furthermore, if 75 ml of this mixture is discarded before the I.V. tubing is attached to the patient, all the non-specific insulin binding sites in the glass and/or plastic will be saturated with insulin. Essentially 100% of insulin in the remaining solution (425 ml) will enter the patient.

Advantages of low-dose insulin infusion in the treatment of DKA

Table 3

INSULIN ADMINISTRATION: LATER

CONTINUE INFUSION UNTIL —

1. $\text{CHO} \leq 250$, $\text{pH} > 7.3$, Neg. Serum Ketones: Begin S.Q. Insulin
2. $\text{CHO} \leq 250$, $\text{pH} < 7.3$ + Pos. Serum Ketones: Continue Infusion

are listed in Table 4. First of all, it is easy to administer a continuous I.V. insulin infusion. Almost every hospital now possesses an infusion pump apparatus. Even this equipment is not absolutely essential, and the insulin infusion can be given via a "pediatric-drip" set. The ease of administration should, of course, not allow one to become overly confident in approaching the treatment of DKA, a clear medical emergency, but should permit one to direct his/her attention more fully and carefully to other problems in the management of DKA, e.g., fluid and electrolyte therapy. A second major advantage of low-dose insulin infusion is that one can predict and control metabolic recovery. If the correction of hyperglycemia is occurring either too fast or too slow, one can change the rate of insulin infusion and, within 10 minutes, the rate of fall of the blood glucose will be appropriately altered. In other words, moment-to-moment adjustments in insulin therapy are indeed reasonable. Third, complicated formulas for the administration of insulin are not required. The application of a sample mixture of insulin and saline at an easily calculated rate of infusion will insure proper insulin administration to patients with DKA. Finally (bicarbonate therapy will be discussed later), because rapid, wide swings in blood glucose concentrations are less likely to occur with low-dose insulin infusion, resultant hypoglycemia and/or hypokalemias are infrequent problems.

To summarize this information, low-dose insulin infusion is at least

Table 4
ADVANTAGES OF CONTINUOUS INSULIN INFUSION

1. Ease of Administration
2. Predictable Control of Metabolic Recovery
3. Complicated Formula for Insulin Not Required
4. Hypoglycemia and Hypokalemia Less Likely
5. Bicarbonate Usually Not Required

an acceptable alternative to the traditional I.V. and/or subcutaneous "bolus" insulin injection in the management of DKA. For those students, housestaff and physicians who are in the process of understanding and learning how to care for patients with DKA, low-dose insulin infusion offers considerable theoretical and practical advantages. For physicians who feel comfortable and confident in using the time-tested standard bolus insulin technic for treatment of DKA, low-dose insulin infusion is not absolutely necessary. If problems in the management of this condition have been experienced in the past, however, the thorough understanding and proper application of low-dose insulin infusion in DKA is clearly justified.

The second principle in the treatment of DKA is that of replacing the deficits—fluids and electrolytes. This requires knowledge about what has been lost.⁴ The patient with moderate to severe DKA is deficient approximately 100 ml per kilogram body weight or, in the average per-

son, (70 kg) 7 liters of fluid. A deficiency of 7 mEq/kg I.B.W. of sodium and chloride also exists. In terms of potassium, 5 mEq/kg I.B.W. (350 mEq for the 70 kg individual) needs to be replaced. While individual patient variation occurs (e.g., the longer the episode of DKA, the greater the fluid and electrolyte loss), these guidelines are important factors in correcting existing deficiencies.

There are many formulas, including Table 5, for the correction of volume deficiency in DKA. During the first two hours, when expansion of intravascular volume is essential, most patients with DKA probably (although there is no hard data) would benefit from the administration of 2 liters of isotonic saline. Subsequently administration of either 2 liters of half-normal saline or, as is frequently required, when the blood sugar has decreased to 250 mg% and continued insulin infusion is necessary, half-normal saline with 5% glucose is appropriate. During the next 8 hours half-normal saline or D₅W half-normal saline is continued. Frequently at this time, however, patients can take fluids by mouth, the safest route of replacement. In summary, fluid replacement in DKA is a critical and essential aspect of the treatment of DKA, equal in its importance to the replacement of insulin; administration of two liters in two hours, two liters in four hours and two liters in eight hours is a reasonable technic. Finally, it is imperative that fluids be given by a second I.V. route separate from the route of continuous intravenous insulin administration, so that there will be no confusion in the rate of administration of either solution.

To examine potassium metabolism in DKA, despite a normal serum potassium level when DKA is initially diagnosed, total body potassium loss in DKA is substantial (5 mEq/kg I.B.W.). Replacement is difficult, yet critical, because as acidosis and hyperglycemia are corrected potassium re-enters the cell.

Table 5

FLUID REPLACEMENT IN D.K.A.

<u>Hours of Treatment</u>	<u>Fluids</u>
1 st 2	2L. of (N) Saline
Next 4	2L. of 0.45% Saline (D ₅ W - 0.45% Saline if CHO 250-300)
Next 8	2L. of D ₅ W - 0.45% Saline (Freq. Some Fluids P.O.)

Table 6

POTASSIUM THERAPY IN D.K.A.

Initial Serum K	Replacement	Time
High	KCL (20-30Meq/L.) or K ₂ HPO ₄ (5ml - 15mM PO ₄ & 22Meq K/L.)	3-4hrs, as CHO ↓, Urine ↑, K <u>Begins</u> ↓
Normal	" " "	1-2 hrs, as CHO ↓ & Urine ↓
Low	" " "	Immediately; No Later Than 1 Hour

Unless one carefully corrects potassium deficiency, muscle weakness, respiratory paralysis and cardiac arrhythmias are inevitable. Prevention of these problems is facilitated by classifying patients with DKA into those with a high, normal or low initial serum potassium (Table 6). Patients may present with an elevated serum potassium concentration despite total body potassium deficiency. As the hydrogen ion from the acidosis enters a cell, another cation-potassium leaves the cell and enters the vascular space. Much is lost in the urine, but the serum potassium level usually remains normal or elevated. For those patients with an elevated serum potassium concentration, one generally waits 2-4 hours until acidosis and/or hyperglycemia are improved and urine flow is established. Depending on subsequent electrolyte determinations, 20-30 mEq of K⁺ per liter of I.V. fluid may then be instituted. If the initial serum potassium is normal despite metabolic acidosis, the risk of ultimate hypokalemia is substantial, and potassium should be begun within 1-2 hours. In 10% to 15% of patients with DKA, the initial serum potassium is low, despite acidosis, indicating severe total body potassium deficiency. Potassium replacement must be initiated immediately to prevent subsequent hypokalemia.

By tradition, potassium solutions have usually been administered in the form of potassium chloride. Recent studies of phosphate metabolism indicate that, like potassium, the serum phosphate level is initially

normal in DKA despite significant total body phosphate depletion (1 mM/kg body weight). During treatment phosphate also re-enters the cell and the circulating phosphate level remains low for several days. There is increasing interest in the "low phosphate syndrome," a clinical problem which may be manifest by hematological disorders, central nervous system dysfunction, heart failure, rhabdomyolysis, liver disease and rheumatic symptoms.⁵ While all these manifestations are not observed in DKA, it is interesting that C.N.S. dysfunction and heart failure do occur in some patients after treatment, one reason to be concerned about phosphate depletion.

Alterations in red blood cell 2, 3-diphosphoglycerate (2,3-DPG) levels are a second reason to be aware of phosphate metabolism in DKA. This red blood cell glycolytic compound is very important in the regulation of the delivery of oxygen such that when the concentration of this substance is low, hemoglobin tends to hold onto oxygen and will not release it to the peripheral tissues. One of the major causes of low 2,3-DPG levels in DKA is the urinary loss of inorganic phosphate. Tissue hypoxia has been documented after treatment of DKA, and there are clinical studies indicating a lowered mortality and a more rapid correction of 2,3-DPG levels with improvement in CNS function when phosphate solutions are given. Since one has to administer potassium, it

is, therefore, reasonable to give it as potassium phosphate to correct both deficiencies. Potassium phosphate solution contains 3 mM PO₄/ml or 4.4 mEqK/ml. Adding 5 ml of this solution to each 1,000 ml of fluid (6 liters) will provide 90 mM PO₄ (all that is needed) and 132 mEq K⁺ (half of what is needed).

The final area of discussion in DKA is acidosis and its treatment. Acidosis is essentially due to the hepatic production of acetoacetate and β -hydroxybutyrate in excess of urinary loss and peripheral uptake and utilization of these ketone bodies.⁶ While I would prefer that patients not be acidotic, if one examines studies on the effects of metabolic acidosis in humans, there is simply not a lot of good information. Generally, these investigations in humans and in animal models demonstrate that with serum pH less than 7.1, one can document left ventricular myocardial depression, cardiac arrhythmias and diminished cardiac and arterial responses to various circulating vasoconstricting substances.⁷

What about the risks of acidosis in DKA? As is apparent from the applicability of low-dose insulin infusion in DKA, acidosis does not appear to convey any kind of "insulin-resistant state." Furthermore, the extent of coma in DKA does not correlate with the degree of arterial acidosis, but is related to the severity of hyperglycemia and hyperosmolality in these patients.⁸ Finally, systemic acidosis appears to have no independent effect on ultimate mortality in DKA. The results of three large series reveal no clear relationship between the serum pH, CO₂ content, degree of ketonemia and subsequent mortality in DKA.⁹⁻¹¹

Table 7

D.K.A. & MORTALITY: CORRELATIVE FACTORS

AGE

COMA (Esp. 12 hrs. \bar{p} Admission)

↑ BUN & ↑ CHO

↑ OSMOLALITY

COMPLICATIONS (e.g. M.I., Infection)

Important factors influencing outcome in DKA are listed in Table 7: age (the older the patient, the greater the chance of mortality); the degree of coma (especially if that coma persists 12 hours following admission); the severity of volume depletion (or loss of free water as reflected by increases in BUN, hyperglycemia and osmolality), and the presence of other complications (e.g., myocardial infarction, infection, etc.). These factors, not systemic acidosis, predict survival in DKA.

If it is difficult to demonstrate dangers of acidosis, are there problems with rapidly correcting acidosis? The answer is "yes" and the reasons are listed in Table 8. Propensity for hypokalemia, so-called "paradoxical" C.S.F. acidosis (falling C.S.F. pH as systemic acidosis improves), and cerebral hypoxia (shift of the oxygen-saturation curve to the left with resultant increased hemoglobin affinity for oxygen) all may occur if acidosis is too rapidly corrected. To appropriately manage acidosis in DKA, if the patient has a pH level <7.1 or a CO₂ content <5 mEq/liter, or, clearly, if the patient is hypotensive, 1 to 2 amps of sodium bicarbonate needs to be administered to *begin* to correct the acidosis. To *complete* the task, ade-

Table 8
D.K.A.: PROBLEMS WITH HCO₃

1. Hypokalemia
2. C.S.F. Acidosis
3. Cerebral Hypoxia
4. Tetany (If Hypocalcemic)
5. Late Metabolic Alkalosis

quate fluid and insulin administration is both sufficient and safe.

To put all this information together: On the one hand, there are many important aspects of DKA which haven't been presented, including the need for accurate, sequential treatment records and intelligent approaches to the use of nasogastric suction in patients with DKA. On the other hand, we've discussed many formulas, facts and figures, information which would fall into the category of "medical recipes." Yet, the most important aspect of DKA is not primarily how much or when, but you and me—the responsible physician. No matter how you approach the problem, no matter what type of therapeutic intervention you choose, the responsible physician remains the most significant ingredient.¹² Finally, despite the fact that considerable knowledge is available about the pathogenesis and treatment of

DKA, 3% to 5% of the patients die of DKA. Clearly now it's time to return to the third principle, that is, trying to identify the precipitating event. And while treatment of DKA is important, prevention is golden. The truly outstanding physician is not only the one who merely corrects DKA but the one who keeps the patient out of it in the first place.

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References pertaining to the papers by Dr. Mohammed Nasser Shinwarie, M.D. (which appeared in the March Journal and was titled "The Comparative Value of Sputum on Blood Cultures in the Diagnosis of Acute Bacterial Pneumonia") and Drs. Isch, Jolly and Shumacker (which appeared in the February issue and was titled "Myocardial Revascularization in Acute Myocardial Infarction") may be obtained by writing to The Journal, 3935 N. Meridian St., Indianapolis 46208.

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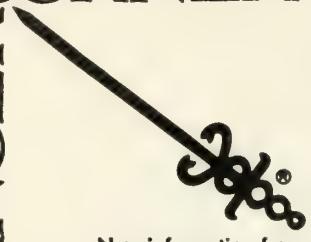
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New information from
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LAETRILE — American Medical Association Resolution.

At its meeting in Philadelphia in December 1976 the AMA House of Delegates considered a resolution on Laetrile (amygdalin). The wording of the resolution that was adopted is as follows:

"RESOLVED, That the American Medical Association continue to inform the public of the danger of delay in the diagnosis and treatment of malignancies by methods not generally recognized by the medical profession as beneficial and effective; and be it further

"RESOLVED, That the American Medical Association inform the public that the safety and efficacy of amygdalin for the treatment of palliation of malignancies is unproven and that the use of amygdalin in such cases exploits the victims of malignancies and their families by preying upon the emotions of the hopelessly ill, in some cases for the profit of the unscrupulous."

* * *

Articles on laetrile are available by checking and mailing the order

blank below to the Indiana Division, American Cancer Society, 2702 E. 55th Place, Indianapolis 46220.

* * *

THE THIRD ANNUAL CANCER SYMPOSIUM FOR THE PRIMARY CARE PHYSICIAN

June 3, 4, 5, 1977

Louisville/Clarksville Marriott Inn
Sponsored by: Indiana Division, American Cancer Society and Methodist Hospital Graduate Medical Center, Indianapolis, IN

The purpose of this symposium is to present new advances in the diagnosis and treatment of cancer which are of practical importance to the primary care physician. Sessions are open to all members and students of the medical profession. Registration fee is \$35. Registration information is available through the Office of Clinical Oncology, Methodist Hospital, Wile Hall, Room 406, 1812 N. Capitol, Indianapolis 46202 (317-927-3159)

Friday — June 3

LYMPHANGIOGRAPHY — 1977

Patrick A. Dolan, M.D., Director of Radiology, Methodist Hospital
ADVANCES IN RADIOISOTOPE SCANNING

Larry A. Heck, M.D., Associate Radiologist, Methodist Hospital

CAT SCAN AND/OR BRAIN SCAN
Don Hardman, M.D. and Larry A. Heck, M.D., Associate Radiologists, Methodist Hospital

LIFE THREATENING INFECTIONS IN THE CANCER PATIENT

Gordon Trenhom, M.D., Assistant to the Chief of Infectious Disease, Rush Presbyterian Hospital, Chicago
TREATMENT OF HODGKIN'S AND NON-HODGKIN'S LYMPHOMA

Lawrence H. Einhorn, M.D., Ass't Professor of Medicine, Dept of Oncology, IUMC

CANCER QUACKERY — A CRUEL HOAX

William M. Dugan, Jr., M.D., Hematology/Oncology Service, Methodist Hospital

PRIMARY CARE PHYSICIAN AND CHEMOTHERAPY DECISIONS

Laurence H. Bates, M.D., Hematology/Oncology Service, Methodist Hospital

THE CANCER PATIENT — TO UNDERSTAND IS TO LISTEN

Kenneth Reed, Ph.D., Director of Chaplaincy, Methodist Hospital and Donna J. Minnick, Associate Program Director, Clinical Oncology Program, Methodist Hospital

Saturday — June 4

BREAST CANCER AND ESTROGEN RECEPTORS

James Wittliff, Ph.D., Professor/Chairman, Dept of Biochemistry, University of Louisville

LABORATORY DIAGNOSIS OF MULTIPLE MYELOMA

James Biesecker, M.D., Ph.D., Pathologist, Methodist Hospital

COLORECTAL CANCER — SCREENING AND DETECTION

Philip A. Christiansen, M.D., Head, Division of Gastroenterology, IUMC
MALIGNANT TESTICULAR TUMORS — RECENT ADVANCES IN CHEMOTHERAPY

Lawrence H. Einhorn, M.D. Ass't Professor of Medicine, Dept of Oncology, IUMC

Continued on page 206

Please send me one copy of each of the following, as marked:

- 1. UNPROVEN METHODS OF CANCER MANAGEMENT — 1976 (ACS Handbook)
- 2. LAETRILE (ACS background statement)
- 3. HEW BACKGROUND STATEMENT ON LAETRILE
- 4. STATEMENT ON LAETRILE by Frank J. Rauscher, Ph.D. (former director, NCI)
- 5. AMA RESOLUTION ON LAETRILE
- 6. LAETRILE: FOCUS ON THE FACTS (Interview with Robert Eyerley, M.D., chairman, ACS Committee on Unproved Methods)
- 7. QUESTIONS MOST FREQUENTLY ASKED ABOUT LAETRILE (ACS California Division)
- 8. 8 COMMONLY MADE STATEMENTS ABOUT LAETRILE (William M. Dugan, Jr., M.D., president, Indiana Division, ACS)
- 9. LAETRILE: FDA CONSUMER MEMO, 1974
- 10. "US v. THE CANCER-

CURE SMUGGLERS" (NEW TIMES, 2/18/77)

- 11. "LAETRILE SMUGGLING DRAMA HITS THE COURTS" (MEDICAL WORLD NEWS, 6/28/76)
- 12. "THE VITAMIN FRAUD — CANCER QUACKERY" — David M. Greenberg, Ph.D. (WESTERN JOURNAL OF MEDICINE, 4/19/75)
- 13. "LAETRILE FOR CANCER" — Thomas A. Jukes, Ph.D. (JAMA, 9/13/76)
- 14. ABSTRACTS OF THREE CONTROLLED TESTS WITH LAETRILE

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MAC Not Needed

THE Pharmaceutical Reimbursement Board is a five-member body appointed to determine reimbursement limits for prescription drugs in Medicaid and Medicare programs. The Board sets the Maximum Allowable Cost or MAC for scheduled prescription drugs.

The government does not dictate what drugs should be prescribed but will reimburse the patient only up to the cost of what the government determines is the cheapest form of the given drug which is considered by federal officials to be equally safe and effective.

The Reimbursement Board recently called an informal hearing coincident with the announcement that the MAC for ampicillin was to be 7.25 cents per 250 mg capsule and 13.9 cents per 500 mg in both trihydrate and anhydrous formulations. Ampicillin is the first drug to be considered for MAC.

C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, spoke at the informal hearing of the PRB. He refuted the government philosophy that MAC is needed to create a competitive market for drugs. He used ampicillin as an example of the government offering a solution to a problem which never existed.

The bulk of the ampicillin market is accounted for by the six most-prescribed brands. Stetler said the six brands clustered around a price of 20 cents per capsule in 1969 and

in 1976 were around six cents per capsule. *During the time the All Commodities Wholesale Price Index rose 77% the six brands of ampicillin reduced prices by about 70%.*

Stetler further stated that:

We remain convinced . . . that MAC is neither needed nor sound. It cannot save the money its proponents claim for it, it will disrupt an established and efficient drug distribution system, and it will poorly serve the long-term health interests of the American people.

Stetler also said:

What we continue to question is this: How can the government decide that the prices of products from a quality and research-based firm should be no higher than those of firms which operate with possible marginal standards and conduct no research?

Health Industry a "Public Utility"?

IT is evident that the health care industry is gradually becoming so beset with rules and regulations that it resembles a public utility. However, James Hickey of the Alexander Grant accounting firm points out that there are two important differences. The health industry is getting all the disadvantages of a public utility, in that the regulations are imposed by many different entities without any coordination between the regulatory bodies. At the same time, the health industry is denied the advantage of the financial responsibility which is the basic concern of the utilities which are regulated by a

single government body.

Standard public utility regulatory agencies are responsible for the financial stability of each member of the system. Medical care facilities and especially hospitals are subject to overwhelming forces to improve quality of care and decrease the cost. Moreover, the medical forces come from many sources—rate setting commissions, third party payers and many voluntary organizations which are increasingly critical of patient care costs. Peer review groups, PSRO, accrediting commissions and licensing bodies all have their high standards and peculiar sets of guidelines. Medical specialty groups, despite good intentions, add to the confusion.

Mr. Hickey also points out that public utilities and health services today share four major similarities:

1. Both provide essential public services.
2. Both have controlled access to an operating franchise.
3. Both are subject to external control by regulating agencies.
4. Both are subject to significant fiscal controls by external organizations.

Despite these similarities, the public utilities are thriving and many hospitals are suffering with a host of uncoordinated and inexorable pressures and controls.

The health service industry suffers from the fact that the forces which control it have no responsibility for its financial health.

While There's Life, There's Risk

THE journal *Massachusetts Physician* for February 1977 contains an editorial on "The Risk of Living" which shows how far afield we can be carried by a philosophy of life based on a false premise. The physician is involved in this and since "the M.D. is often the key person involved in other people's adversities he receives an unfair share of . . . blame."

A major portion of the editorial is worth some of this journal's limited space, as is apparent in the following:

Not so many years ago, when adversity, disease or death hit one of us, there was just as much grief, but there was also a certain sense of inevitability and a recognition that in spite of what anyone, including the M.D., did, living carried with it certain risks which were inescapable.

Society Blamed

As time passed disease and death became more and more attributed to specific occupations, contaminated food, faulty working conditions, psychic trauma or to many other environmentally related factors. The worker, occupied in living, began to blame his employer, i.e., society, for all the ills which befell him. He was not supposed to get heart attacks, cancer, pneumonia or schizophrenia; and, therefore, if he did, it must be society's fault and society must provide adequate compensation.

We constantly play down the risks and imply that everyone is entitled to live out a disease-free life with adequate income and no worries. In this way we have created a generation of people who automatically blame society or some of its members for anything less than a perfect solution to every problem.

Having created this monster, we find it difficult to destroy it. The

cure consists of daily doses of truth by everyone able to peddle it. There is a real risk in living. We will all become ill and die. Some will succumb much earlier than others but in any case society, and the physician members of it, are to blame for very little of what happens to the individual.

Lawyers will not be happy with such a concept. They have been in the forefront of those pushing the idea that society is to blame for all adversity. A cause-and-effect relationship is discovered in every disaster which befalls their clients.

Social workers, sociologists and a host of other do-gooders will consider us heartless rascals for implying that maybe the reason things went badly was just tough luck and a part of living we have to learn to accept. Nevertheless, the sooner we get back to a recognition of the risk of living and an acceptance by everyone of that risk, the happier we will all be.

After all, the risk of living is somewhat like the responsibility of liberty as opposed to the license of anarchy. Without the spur of risk *Homo sapiens* would, in effect, regress to a level with the invertebrates.—A.W.C.

As Others See Us

NEARLY two centuries ago, Bobby Burns penned the wish: "Oh wad some power the giftie gie us

To see ourself as others see us."

The Star has been privileged recently to obtain that sort of a look at Indianapolis, not a total one but a description of a sizable part of our economy. The study was done by an outside firm, which is just beginning to handle our national advertising.

Using Sales Management figures, they came up with these observations: Indianapolis is one of 10 midwestern metropolitan areas with more than a million population. We're ninth in population but in

per household figures Indianapolis is 2d in retail sales, 3d in auto sales, 2d in building material and hardware sales, 4th in department store, drug store and eating and drinking sales and 4th in passports. We do a lot of driving. We're first in gas service station sales, and we're second in this area in population growth between 1970 and 1975.

Compared with the entire United States, our area is 28th in population but we're the 11th fastest-growing area, 4th in retail sales and again first in gasoline station sales.

It may be true that liars figure and figures lie. But in this case, the figures portray what Indianapolis is: a solid, growing, busy community. We weathered last year's recession better than most and our unemployment is well below national or midwestern averages.

We shouldn't become complacent but we should keep working at the things that have made all this happen: sensible government, diversified businesses, low public debt, good stores, living within our means, fine cultural and educational institutions and a concern for the less fortunate.—E. S. Pulliam, "Publisher's Memo," *The Indianapolis Star*, Jan. 16, 1977. Reprinted with permission.

Generic Names

WE suspect that most of our readers feel the same as we do about the exclusive use of generic drug names in some scientific articles. Quite frankly, we frequently have no idea what drug or even general drug category the author is talking about. Beyond that, we don't even know where to look to find a translation of the generic terms into a drug list with which we are familiar.

It might be perfectly obvious to those in an academic setting or within the tight confines of a specialty group when one of them goes around talking about Chlordiazepoxide. Perhaps they do talk like that all day, but it would seem a lot easier just to say *Librium* if

that's what they mean. It all seems a little phoney. An affectation. Using a broad "A" when you're not even from Boston.

It might make points with the Professor or the Dean but it sure does not make points with the guys out in the trenches. They read such articles, not for intellectual exercise or to go one up on a colleague in the hospital cafeteria the next day, but for help in treating patients. They need this help and they want to get it quickly without getting bogged down with 10-syllable chemical names.

We're not going to worry about giving some drug manufacturer a free boost by naming his trade-named product. Not if it helps us to understand or get the point of an article. We are going to start insisting that our authors identify the drugs they are talking about by indicating some recognizable trade name after the fancy name.

We hope this meets with the approval of everyone. — **Reprinted with permission from the January 1977 issue of *The West Virginia Medical Journal*.**

Editorial Notes . . .

An insurance company in Toronto, Canada, has announced a new and unique policy to cover the legal costs of defendant physicians in malpractice litigation. It is especially for those who have gone "bare." Rates vary with specialties and location but will range from \$500 to \$1,000 annually.

Over 25 million prescriptions are filled by mail each year. The Veterans Administration, alone, fills about 16 million a year. The National Retired Teachers Association dispenses over 4 million Rx's annually from seven regional pharmacies. Now that the Supreme Court has said that prescription price advertising is not illegal, there is still the ethical objection that the transaction prevents the personal advisory functions of the pharmacist.

Medical education statistics:

1. 114 U.S. medical schools.
2. Total enrollment last year—56,244.
3. Increase over previous year—2,170.
4. First-year enrollment last year—15,351.
5. Increase over previous year—388.
6. Women enrolled last year—11,527.
7. Increase over previous year—1,741.
8. Full-time faculty members—39,330.
9. Teacher to student ratio—1.4.
10. Part-time teachers—more than 70,000.
11. The 15,351 admitted last year were chosen from 42,303 applicants, a multitude which was slightly smaller than formerly for the first time in many years.

"Health News Report" reports: "Our nation may go bankrupt through efforts to cure the sick unless Americans begin to accept more personal responsibility for their own care." This quotation from D. Eugene Sibery of the national Blue Cross Association is another way of saying there is not enough money in the world to provide all the modern up-to-date medical service that the American people will absorb if it is provided without limitation. Mr. Sibery blames public-health education, or rather, the lack of proper health education. He thinks it should be taught early in the curriculum and should be taught in much, much better fashion than it is now.

The Medical College Admissions Test is being revised. The 30-year-old test, according to "Health News Report," will be twice as long (one day) and will be broadened to include problem-solving skills that physicians would need in ordinary office practice. The old test, some-

times referred to as an aptitude test, tested biological science knowledge but was short on real aptitude as-say. The new test will cover basic science, reading and mathematical skills and problem solving. Sixty thousand students are expected to tackle the first round with the new setup.

The VA requested appropriation for Fiscal Year 1978 adds up to \$18.4 billion. This covers all programs for 29.7 million veterans and their dependents. Proportionately, the tab amounts to 3% for general operating expenses, 67.1% for direct payments to beneficiaries, 27% for medical programs and 2.9% for construction. ◀

There's A Word For It

RICHARD J. NOVEROSKE, M.D.
Evansville

Small Finger

I think "small finger" is the best term for the smallest, or fifth, digit of each hand.

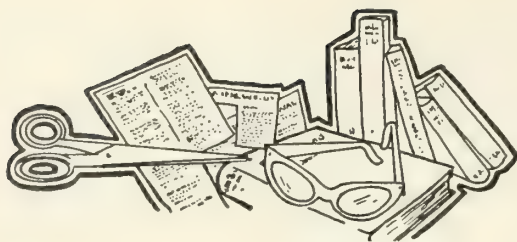
"Little finger" is used more widely than "small finger," but "small finger" has two advantages over the term "little finger."

It's shorter; one syllable instead of two. And this is one of the fundamental guides of anatomical nomenclature since the BNA terminology was started—use the shortest term whenever practical.

Second, "small" doesn't sound like "middle" to the typist who takes your dictation, or the audience who listens to you, or the patient who is straining to take in everything as clearly as possible. "Little" does sound like "middle," and this sound-a-like can create errors. Why make it harder to communicate?

Let us in medicine do it the easy way and say "small finger."

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BOOK REVIEWS

SURGERY OF THE URETER (HANDBUCH DER UROLOGIE), ENCYCLOPEDIA OF UROLOGY III

R. Kuss and C. Chatelain (translated from the French by A. Walsh), Springer-Verlag, New York, Heidelberg, Berlin, 1975; \$98.50.

The European medical writers have a facility for graphic narrative and they seem to be able to convey complex ideas and procedures proficiently. They aren't fearful of using the personal pronoun. This book on surgery of the ureter partakes of these good European tendencies, I believe. The inflated cost doesn't detract from this excellence.

Many aspects of ureteral surgery are covered. The surgical approaches, -otomies, -ectomies, anastomoses, -plasties and so on are all here. The format includes a summary of historical precedence of original surgeons, the procedure itself, modifications, indications and results. Two hundred thirty-three figures define the text most thoroughly. A bibliography at the end contains hundred upon hundreds of references.

The authors seem not to be fixated on "pet" procedures but give mature and balanced coverage to all acceptable methods. If unacceptable, they don't flinch from telling the reader.

All in all, a very fine and useful production. I wish I had the first two volumes of the "Encyclopedia" for my library.

RODNEY A. MANNION, M.D.
LaPorte

CLINICAL METHODS—THE HISTORY, PHYSICAL AND LABORATORY EXAMINATIONS VOLS. 1 AND 2

H. Kenneth Walker, M.D., W. Dallas Hall, M.D., J. Willis Hurst, M.D., Butterworths, Boston, 1976.

CLINICAL METHODS can best be described in the modern jargon as a happening, a promising approach to the patient and to the solution of his problems. The basis for this two-volume work, edited by three members of the Department of Medicine, Emory University School of Medicine, and with the multiple authorship of members of the Emory faculty, is the "defined data base" developed on the medical service of Emory at Grady Memorial Hospital, Atlanta. In the words of the editors, "This Data Base responds to the needs of our patient population and aids our teaching of students and house officers."

What the book does is to present the most modern clinical examination techniques in a usable and accessible format. Two hundred forty-three "clinical items" are presented, each item composed of 1) definition, 2) technic, 3) background information, 4) clinical significance, and 5) selected references.

Information is presented under the item headings (e.g., hypertension, hematuria, jaundice) in a way that capitalizes on basic science knowledge.

The general approach was originated in the 1960s by Dr. Lawrence Weed and was known as the problem-oriented medical record (POMR). The problem-oriented medical record can be exemplified by an encounter between a clinician and a patient. The presenting complaint is headache. On physical examination, the clinician discovers an enlarged thyroid gland. The laboratory report reveals anemia. The clinician collects data in history, physical exam and laboratory exams related to the three problems, arranging the facts related to each problem and, in effect, establishing a logic bridge. This approach is drastically different from the conventional routine where information is entered according to the source from where obtained. In the latter approach, there is no logic pathway, and facts are not readily accessible. A technical term used in discussing the approach is the "defined data base." It has several subheadings. The "comprehensive care data base" identifies existing and potential problems in a specific patient population. A "specialty data base" includes problems related to the general health of the patient and those which concern the specialty. A "problem specific data base" deals with exactly defined problems, such as diabetes or hypertension. Each data base contains relevant items from the history, physical and laboratory exams.

In using the manual, one turns to the topic of immediate interest (e.g., chest discomfort or pain). He reads the definition, then the technic of understanding the problem as presented by the patient. Next, background information is covered, and then the clinical significance of different types of chest pain. Finally, selected references are presented. For this particular item and for the various other items covered, the clinician is placed in the position of being able to proceed logically and systematically.

Your reviewer has tested the approach for several items with which he is familiar and for several which lie outside his field of intimacy. In each case, the information obtained proved of material help.

One aspect of this approach to the patient that is particularly appealing is its consideration of the whole patient. One leafing through volumes may be startled by such items as usual day's activities, finances, change in mole, in addition to the more conventional entries, such as fever and chills, night sweats and vomiting. Yet, even these unconventional items are frequently indispensable in studying a given patient.

An outstanding advantage to the approach presented in CLINICAL METHODS is the focusing on specific channels of investigation. As the editors point out, the universe of information concerning each patient is potentially infinite. Defining the data base spells out in precise terms what should be done in the case of a given patient. The authors are careful to point out that the system they present is tailored for the patient population seen at Grady Memorial Hospital in Atlanta. Therefore, it may have to be modified somewhat for other patient populations.

To obtain a clear understanding of this approach to the patient, it would be necessary to peruse the volumes. The method impresses this reviewer as logical, analytical, integrated, and an enormous contribution to the best and most economical use of clinical and laboratory examinations. The book has a limited number of charts and line drawings. It has plastic covers with firm celluloid bindings; these make for ready use of the book, which falls open at any point. The first volume contains 420 pages, the second, 1,098, which includes a useful index. The volumes are strongly recommended for all clinicians, but in particular for family physicians and internists.

W. D. SNIVELY, JR., M.D.
Evansville

ODDS & ENDS OF WARD WIT

Thelma Canarecci, R.N., Medical Economics Co. Book Division, Oradell, N.J., 1976. \$4.95.

Mrs. Canarecci is blessed with a precious and priceless sense of humor. She lets it all hang out where you can enjoy it in ODDS & ENDS OF WARD WIT. Adjectives pop into my mind when I try to characterize this book: ingenious, innovative, imaginative, sometimes risqué, sometimes subtle, always delightful. Most of the quips are built around the biologic symbols for male and female. Others Mrs. Canarecci drew with ruler and template with some help from her art-teacher daughter.

EKG graphs, x-rays, footprints, views through a microscope, puns (what else is a *corynebacterium* but a *corny bacterium*?) combine in an unholy alliance to make this book hilarious. Some of the humor hits you immediately, some requires a little reflection, some may just bug you for a while. But to really savor the flavor of this little masterpiece you'll have to read it yourself. In fact, this reviewer strongly recommends that you do just that—promptly! Attractively bound in a hard cover, the book contains 100-plus pages and can be had from Medical Economics Company for a paltry \$4.95. Great for reception rooms, gifts, enjoyable reading.

W. D. SNIVELY, JR., M.D.
Evansville

TLC—One of Mrs. Thelma Canarecci's cartoons appears on page 170. This talented Hoosier nurse lives at Mishawaka and draws upon years of nursing experience and observation of the hospital and medical scene. Her daughter, Mrs. Laura Addison (whose first initial appears in the signature "TLC"), has had a recent opportunity to add to her sketchbook of ideas, for she was a maternity patient last month and promoted Mrs. Canarecci to the rank of grandmother.—J.J.R.

BASIC CIRCULATORY PHYSIOLOGY

Daniel R Richardson, Ph.D., Little, Brown and Company, Boston, 1976.

Recognizing that not only medical students but allied health professionals require a working knowledge of circulatory physiology, the author offers a thoughtful and innovative approach to teaching the subject. Designed for use either as a text for classroom study or a manual for independent study, the book divides the subject into six distinct and clearly delineated chapters:

- I. Components of the circulatory system
- II. Structure and electrical activity of the heart
- III. Mechanical activity of the heart
- IV. The low pressure (venous) system
- V. The microcirculation and regulation of blood flow
- VI. Systemic regulation of cardiovascular function

The book employs advanced instructional techniques; thus, each chapter is preceded by instructional objectives and performance objectives. The former state the goals of the teaching and the latter what the student will be expected to know and do after the course of study. There are numerous clear charts and graphs along with generous use of mechanical analogies. The manual is paperback, has some 172 pages and is well indexed. Dr. Richardson is associate professor, Department of Physiology and Biophysics, University of Kentucky College of Medicine, Lexington.

The book is recommended for medical students, bioengineers, critical care nurses, dental students, pharmacists, intravenous therapists, nephrology nurses, nurse anesthetists, and students preparing for these courses of study. *It is also recommended for physicians who desire to be brought up to date on recent developments in cardiovascular physiology*, although this may not be one of the avowed targets audiences.

W. D. SNIVELY, JR., M.D.
Evansville

take
as
needed



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Indianapolis, or you're in town
on business or pleasure,
Yellow Cab conforms to your
schedule with the largest
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Indiana. From the airport to
the hotel and anywhere else
in town, we'll always be there
when you need us. So the next
time you need transportation
in Indianapolis, call Yellow Cab,
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We make house calls.



Where people come first

TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

THE status of the gift tax deductions, after the Tax Reform Act of 1976, is, in one sense, about the same as before the Act. However, from another view, the changes involve concepts which are so complex that it will be years before the average practitioner (or tax lawyer, for that matter) is able to predict the specific ramifications of lifetime transfers under the new law.

Prior to the new law, there were three gift tax deductions and each of these deductions was deductible from gross gifts in arriving at taxable gifts. The three deductions *used* to be for: charitable gifts under §2522; gifts to spouses under §2523, that is, the marital deductions; and, the \$30,000 lifetime exemption under §2521.

As to the charitable deduction of §2522, it has been limited in one respect, and expanded in another. However, these changes are not worth discussing here.

As to the marital deduction of §2523, this deduction has been substantially *increased*. Before the 1976 change, the gift tax marital

deduction was equal to one half of the *total* gifts given by one spouse to the other spouse, but the deduction could exceed gross gifts so given to the spouse. Thus, *each time* that one spouse gave his or her spouse a gift the donor was entitled, in general, to a marital deduction of *one half* of the value of the gift. Further, there was no fixed limitation on the *total* amount of the marital deduction which one spouse could deduct during such spouse's lifetime. For example, assume that D gave a gift of \$20,000 during the first calendar quarter to his or her spouse. Under the former law the total gift was \$20,000. The gift tax exclusion (for a gift of a present interest) was \$3,000, and the marital deduction was 50% of \$20,000, or \$10,000. The only type of limitation which existed under the prior law was under §2524, which section limited the marital deduction to no more than *gross* gifts which were made to the spouse. Thus, if D had only given \$4,000 to his or her spouse during the particular quarter, then his or her exclusion was \$3,000 and such donor's marital deduction was *not* 50% of \$4,000 (namely, \$2,000), but the deduction was limited, under §2524, to gross gifts to the spouse. Namely, to \$4,000 less \$3,000—a total of \$1,000.

Now, the marital deduction has been changed as follows. First, each individual (each spouse) is entitled to a marital deduction of a flat \$100,000. In addition, each indi-

vidual may deduct, one half of the total gifts to his or her spouse, which gifts are *in excess* of \$200,000.

Thus, there is an area between total lifetime gifts of \$100,000 and \$200,000 where the donor spouse will not be entitled to any further gift tax marital deduction. That is, in general, if a donor makes gifts to the donor's spouse in the amount of \$100,000, then the donor will be entitled to eliminate all these gifts, because of the combination of the donor's annual \$3,000 exclusion and the flat \$100,000 marital deduction, or because of the flat \$100,000 marital deduction alone. However, if the donor's gifts to the donor's spouse exceed \$100,000, then the donor will *still* be entitled to the initial flat \$100,000, but the donor will not, in general, be entitled to the marital deduction on the gifts which exceed the initial flat \$100,000. Then, when the donor makes gifts to the donor's spouse, which gifts (combined with the prior gifts to the spouse) exceed \$200,000, the donor will again be entitled to the marital deduction—namely, in the amount of 50% of the amount of the gift in excess of \$200,000.

In my next article I shall continue to discuss the gift tax marital deduction, and present the computations which are involved with typical fact situations. ◀

CANCER CORNER

CUTANEOUS CLUES TO VISCERAL CANCER

William B. Moores, M.D., Dermatology Service, Methodist Hospital
HOSPITAL HOSPICE UNIT: DIGNITY-SECURITY-HOPE FOR THE DYING PATIENT—A PANEL PRESENTATION

William Elliott, M.D., Chairman, Hospice Task Force, Methodist Hospital
Kenneth Reed, Ph.D., Director of Chaplaincy, Methodist Hospital
John R. Woods, Evaluative Research Analyst, Methodist Hospital
Donna J. Minnick, Associate Program Director, Clinical Oncology Program, Methodist Hospital

Sunday — June 5

PAIN MANAGEMENT — BROMPTON'S COCKTAIL

K. Gregory Humma, M.S., Clinical Pharmacist, Methodist Hospital

CLINICAL USE OF BROMPTON'S COCKTAIL

William M. Dugan, Jr., M.D., Hematology/Oncology Service, Methodist Hospital

NON-SMOKERS DO IT BETTER AND LONGER: Breathing — A PANEL PRESENTATION

Eugene Levitt, Ph.D., Dept of Psychiatry, IUMC

Continued from page 200

William Nowlin, M.D., Chairman, Smoking Task Force, Indiana Division, American Cancer Society
Laurence H. Bates, M.D., Hematology/Oncology Service, Methodist Hospital

* * *

Every Physician's Office — A Cancer Detection Center

* * *

WILLIAM M. DUGAN, Jr. M.D.
President, Indiana Division
American Cancer Society

FUTURE MEETINGS, SEMINARS, COURSES

Program on Patient with Diarrhea Scheduled by Washington University

"An Approach to the Patient with Diarrhea" will be the subject of a day-long program to be presented by Washington University School of Medicine at Wohl Auditorium, Barnes Hospital Complex, on April 22. The course is acceptable for hour-for-hour credit in Category 1 of the AMA. Equal credit has been requested from the AAFP. For further information call collect (314) 454-3873.

Breast Cancer Symposium April 30

A symposium on "Cancer of the Breast" will be conducted by the Chicago Medical School on Sat., Apr. 30, at the North Shore Hilton Hotel in Skokie, Ill. The program is approved for 4 hours of Category 1 Postgraduate Education. Regular Course fee is \$50. There is no fee for physicians in training. Deadline for registration is April 15. Write or call Ms. Elaine Huffman, North Chicago Veterans Administration Hospital, Building 50, North Chicago 60064; telephone (312) 473-9200.

21st Annual Fractures/Trauma Course

The Twenty-First Annual Postgraduate Course on Fractures and Other Trauma will be conducted by the Chicago Committee on Trauma of the American College of Surgeons May 11 to 14. Registration fee is \$165; for interns and residents \$55. This includes three luncheons and one reception. The location is the Sheraton-Chicago Hotel. Write the American College of Surgeons, 55 E. Erie St., Chicago 60611.

Symposium on Pain Management

"Current Concepts in Pain Management" is the title of the symposium which has been announced for May 13-14 under the auspices of the Department of Rehabilitation Medicine at the University of Health Sciences/The Chicago Medical School.

Eugene J. Rogers, M.D., F.A.C.P., chairman of the Rehabilitation Department at CMS, is coordinator of the symposium, which will be held at the Ambassador West Hotel. His address is 2020 W. Ogden Ave., Chicago 60612; 312-226-4100.

The program is approved for 16 hours of category 1 credit, AMA Physician Recognition Award, and 16 hours of elective credit—Illinois Academy of Family Physicians. Program charge is \$100, \$30 to physicians in training.

Litigation Influence on Medical Practice Subject of Conference in London in May

The influence of litigation on medical practice will be the subject of a three-day conference May 16 to 18 in London, England. It is sponsored by the Royal Society of Medicine of London and the Royal Society of Medicine Foundation of New York City. The meeting will be held at 1 Wimpole Street, London. Registration fee is \$50, which includes the cost of luncheons, coffee breaks and a copy of the proceedings. Inquiries to the Royal Society at 1 Wimpole St., London W1M 8AE, England.

New Developments and Controversies In Management of Carcinoma of Breast

A two-day symposium on New Developments and Controversies in Management of Carcinoma of the Breast will be held on May 19 and 20 at the Indiana University School of Nursing Auditorium, 1100 W. Michigan St., Indianapolis. Sponsors are the Departments of Radiation, Oncology and Surgery, I.U. School of Medicine, the Indiana Division of the American Cancer Society, and the Marion County Cancer Society—The Little Red Door.

Additional information may be obtained from the Division of Postgraduate and Continuing Medical Education at the School of Medicine; telephone 317-264-8353.

Medical Genetics Course at Ann Arbor

A postgraduate course on "Medical Genetics" will be sponsored by the American College of Physicians at Ann Arbor, May 23 to 25. For full information write to Thomas D. Golehrter, M.D., University of Michigan Medical School, Ann Arbor 48104.

Fourth Annual Mushroom Conference

The Fourth Annual Aspen Mushroom Conference will meet at the Hotel Jerome, Aspen, Colorado, Aug. 7 to 12. AMA Physician Recognition Award up to 30 hours category II. For further information write the Conference in care of Beth Israel Hospital, 1601 Lowell Blvd., Denver 80204.

Conference on Human Values and Cancer

The American Cancer Society Second National Conference on Human Values and Cancer will be held at The Palmer House, Chicago, Sept. 7 to 9. Advance registration is requested. No registration fee. For full particulars write the Society at 777 Third Avenue, New York City 10017.

Conference on Lymphomas and Leukemias Scheduled for New York City by ACS-NCI

The American Cancer Society and the National Cancer Institute announce National Conference on the Lymphomas and the Leukemias, to be held Sept. 29-Oct. 1 at the Waldorf-Astoria Hotel, New York City.

Sessions are open to all members and students of the medical and dental professions. Advance registration is requested; no registration fee. This CME program meets the criteria for 15½ hours of Category 1 credit for the Physician's Recognition Award of the AMA and is also acceptable for 15½ elective hours by the AAFP. Further information is available from Sidney L. Arje, M.D., ACS-NCI National Conference on the Lymphomas and the Leukemias, 777 Third Ave., New York 10017.

The Auxiliary Reports to ISMA

Dear Doctor:



If you were visually impaired, would you be uncertain in the elevator of a public building? Some Girl Scouts in Marion have become aware of the needs of these visually handicapped members of our community. They have helped in several service projects, especially those bringing cheer to elderly, blind shut-ins. Then came the idea of marking elevators, thus giving a measure of independence to those who are still active. Letters were written to other communities to learn how they had marked their elevators and to find a source for supplying the metal plates. Three meetings were held where these ideas were presented to the managers of Marion buildings and a decision made to install the metal plates, in both Braille and embossed letters and numerals, in the tallest building in a trial of

their suitability. It is expected that other building managers will follow.

How about your town?

It is time for another face to appear on this page. It has been my pleasure this year to serve the Auxiliary. I wish to thank them for the opportunity to serve. I would like to express my gratitude and appreciation to our advisors, Dr. William Sholty, Dr. G. Beach Gattman, and Dr. Jack Walker, also the Indiana State Medical Association Executive Director, Mr. Donald Foy, and his staff, for their loyal support and encouragement in all of our endeavors, as well as making us feel an important part of their programs and concerns for Indiana State Medical Association.

April 19-21 are the dates of our 33rd annual state convention at the Ramada Inn in Kokomo. The auxiliaries of Grant and Howard, as well as several other northern area counties, are busily preparing exciting plans and fellowship for this event. I hope you will encourage your spouse to attend. At this time Mrs. John R. Stanley from Muncie will become our 51st state president.

May I again emphasize the importance of your spouse's membership? If she is not a member, I hope you will encourage her to be one. If she is not in an organized county, she may become a member-at-large and still be informed and participate in the many concerns of medicine, and if she is a member, CONGRATULATE her for belonging to a great organization!

Chloe A. Goldsmith

Chloe (Mrs. David A.) Goldsmith
President, ISMA Auxiliary

About Our Cover

Photos taken at the Auxiliary's annual Legislative Luncheon grace this month's cover. In the photos across the top (left) Mrs. H. Carter Dunstone, Fort Wayne, Mrs. Hoyt Gardner, AMA Auxiliary's legislative chairman, and Mrs. Otis R. Bowen are chatting with Representative Dan Huff; and (right) Representative Stephen C. Moberly is with Mrs. Joseph Moheban and Mrs. James Lorber, Shelbyville. Representative E. Henry Lamkin, Jr., M.D., Indianapolis, is at the left of the center row of photographs, with Mrs. David Goldsmith, Auxiliary president, in the center and Representative Joseph P. Harris is seen with Mrs. Leo Watson and Mrs. Sterling Tignor, Kokomo, and Mrs. Ruben Gaboya, Bunker Hill. In the photo at lower left are Representative Thames Mauzy and Mrs. John Arford, Fort Wayne; while those in the lower right photo are Mrs. Robert Schleinkofer, Fort Wayne; Mrs. Gardner, Mr. Richard King, ISMA legislative analyst; Mrs. Frederick Mackel, Huntertown, and Mr. Donald F. Foy, ISMA executive director. Mrs. Gardner and Mr. King addressed the luncheon.



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.
- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg/kg/day in rabbits and 10 mg/kg/day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Antivert[®]/25 
(meclizine HCl) 25 mg. Tablets
for vertigo*

DYAZIDE[®]

Each capsule contains 50 mg. of Dyrenium[®] (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

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MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*

**LOWERS
BLOOD
PRESSURE**

**CONSERVES
POTASSIUM**

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

*** WARNING**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*** Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium[®] (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
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TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE



NEWS NOTES

Hospital Medical Staffs Name Officers

New officers have recently been chosen by some Indiana hospital medical staffs, as follows:

Terre Haute Regional—Dr. Woerner Lowenstein, president; Dr. David Janicki, secretary-treasurer, and Dr. Wayne A. Crockett, president-elect.

LaGrange County—Dr. M. Reed Taylor, president; Dr. M. O. Mellinger, vice-president, and Dr. E. C. Thompson, secretary.

Huntington Memorial—Dr. R. B. Peare, president; Dr. R. W. Wagner, vice-president, and Dr. K. A. Smith, secretary-treasurer.

Daviess County—Dr. Robert L. Heymann, chief of staff; Dr. James Beck, vice-chief of staff; Dr. H. B. Lindsay, secretary. Department heads are Dr. J. W. Barrett, chief of surgery; Dr. Glenn Ross, chief of x-ray; Dr. Marshall Seat, chief of obstetrics; Dr. Charles Cullison, chief of laboratory, and Dr. Donald Hall, chief of medicine.

Major Hospital, Shelbyville—Dr. James Tower, Jr., chief of staff; Dr. L. A. Arata, vice-chief; Dr. Lucia Banguis, secretary; Dr. Thomas Jean, chief of obstetrics; Dr. Lamberto Abeleda, chief of medicine; Dr. William Green, chief of surgery, and Dr. Paul Inlow, chief of emergency room.

Gibson General Hospital, Princeton—Dr. W. R. Wells, chief of staff; Dr. R. G. Geick, vice-president; Dr. J. L. H. Rayes, secretary-treasurer.

Hendricks County, Danville—Dr. James Black, chief of staff; Dr. Steve Irwin, vice-chief; Dr. William Edwards, secretary-treasurer.

Kidney Foundation Elects Dr. Kleit

Dr. Stuart A. Kleit, Indianapolis, has been elected a vice-president of the National Kidney Foundation. He is a professor of medicine and chief of the renal section at the Indiana University Hospitals and has been involved with the National Kidney Foundation since 1971.

Dow Offers Film on TB Management

"Modern Management of Tuberculosis" is the subject of a 16 mm sound and color motion picture presented by the American Lung Association in cooperation with Dow Pharmaceuticals. The 45-minute film is available on free loan to medical schools, hospitals, health agencies and medical societies. Requests to Dow Pharmaceuticals, P.O. Box 68511, Indianapolis 46268.

Orthopedic Surgeons Attain Fellowship

Drs. Robert Cravens, Merrill Ritter and James B. Steichen, Indianapolis, and **Dr. Rajih Y. Haddawi, Bloomington**, were recently inducted as Fellows of the American Academy of Orthopedic Surgeons.

Publish Blood Banking Newsletter

A Newsletter reporting developments and trends in blood banking is offered gratis by Union Carbide Corporation. It is issued bimonthly and covers blood component freezing technics. Requests to Union Carbide, Dept. BBN, 401 Theodore Fremd Ave., Rye, N.Y. 10580.

Physicians Attain Certification

Word has reached The Journal of the certification of a number of Hoosier physicians by various medical specialty boards. They are:

Dr. Frank L. Hilton, Evansville, has been named a diplomate of the American Board of Obstetrics and Gynecology.

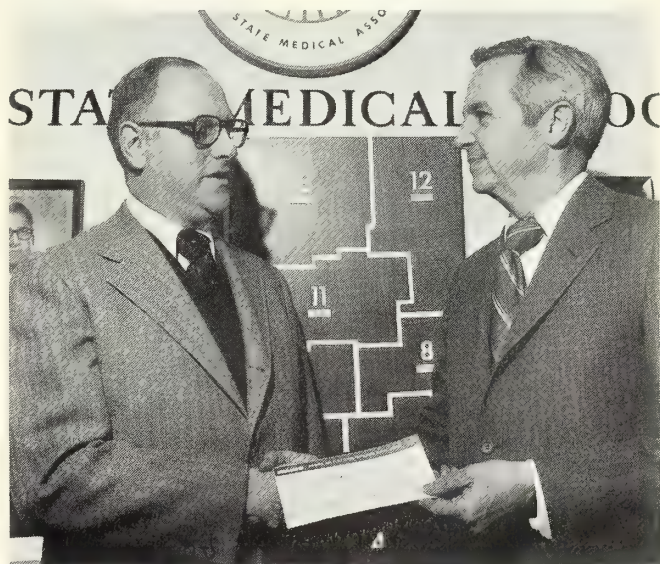
Dr. Earl J. Mason, Hammond, and **Dr. John F. Garvish, Crawfordsville**, have been certified by the American Board of Nuclear Medicine.

M.D. Vacancies in Project USA

Project USA, the American Medical Association's program to recruit physicians for short-term service (usually two weeks) has year round vacancies at Indian Health Service facilities, and National Health Service Corps rural communities. Project USA physicians receive \$500 a week plus round trip air coach fare, and family housing accommodations are provided.

Malpractice insurance coverage is furnished under the Federal Torts Claims Act for service on Indian reservations; however the physician must provide his/her own malpractice insurance at a NHSC site. It is a simple procedure to extend an existing coverage to include short-term service at a NHSC location. Any expense involved in this process will be assumed by Project USA.

Physicians interested in participating in this program are requested to contact John Naughton, AMA, 535 N. Dearborn, Chicago, Ill. 60610; (312) 751-6388.



\$100,000—Steven C. Beering, M.D., dean, I.U. School of Medicine, accepts a \$100,000 check from John W. Beeler, M.D., president, Indiana State Medical Association, in the Headquarters Office. Dr. Beering said the money would be used for the continued growth and development of the Department of Family Medicine, establishment of an office to co-ordinate career education and research, and to defray recruitment expenses to fill vacancies such as the chairmanships of the Departments of Pharmacology and Community Health Sciences. The check was presented on Tues., Feb. 15.

Dr. Wood Elected to Three-Year Term

Dr. Donald E. Wood, Indianapolis, was recently elected to a three-year term on the board of directors of the Indianapolis Chamber of Commerce.

Chest Physicians Elect Dr. Ross

Dr. Joseph C. Ross, formerly a pulmonary internist at Indiana University School of Medicine and presently professor of medicine and chairman of the department of medicine at the Medical University of South Carolina, was elected to the office of president-elect of the American College of Chest Physicians recently at the Annual Scientific Assembly of the College held at Atlanta.

Research Training Grant Received

Indiana University School of Medicine is one of some half-dozen schools chosen to receive a five-year cardiovascular research training grant. The money funds a program which is designed to attract and develop teachers and investigators—rather than practicing cardiologists. I.U.'s first year grant is \$78,000. Fellows for the first year are **Jon Lindemann, M.D.**, Batesville; **Bruce Johns, Ph.D.**, Des Plaines, Ill.; **David Lathrop, M.D.**, Valparaiso, and **Mike Mirro, M.D.**, Merrillville.



HANGER PROSTHESES OFFERS BOOKLET ON AMPUTATIONS

This booklet has been designed for those physicians whose practice includes amputation. **Limb Prosthetics** gives ready reference for each site of amputation as well as the prostheses recommended for each site.

Over 100 years of experience gained by the Hanger organization have gone into this carefully illustrated booklet. Illustrations include amputation sites for the leg and the arm, various Hanger prostheses and methods of suspension, post-operative care and preparation for prosthesis, plus selected photographs showing the child amputee and training for the above-knee patient.

We believe that you will find **Limb Prosthetics** a most useful booklet and a valuable source of quick information. To obtain your copy, please write or phone the Hanger office nearest you.

Hanger
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1332 N. Illinois St., Indianapolis, Indiana 46202
312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

Medicolegal Student Essay Contest

The 1977 John P. Rattigan Student Essay Contest is open to medical students and to students of all other disciplines involved in studies of medicolegal matters. The contest is conducted by the American Society of Law and Medicine, 454 Brookline Ave., Boston 02215. It is financed by a fund contributed by family and friends of John P. Rattigan, M.D., noted medicolegal educator. The essay may cover any subject of medicolegal interest. First prize is \$300, second prize is \$150, third prize is \$100. Deadline is Sept. 15. Write the Society for more details.

Schering Laboratories Offers Film

A new teaching film showing proper technic of avoiding postsurgical hospital infections is now available by courtesy of Schering Laboratories. It is a 14-minute film in color and was produced at Southwestern Medical School in Dallas. To schedule a showing on a free loan basis write Schering at Kenilworth, New Jersey.

Business Consultants' Roster Offered

The Society of Professional Business Consultants publishes a roster of its members, all of whom work exclusively for physicians and dentists. Services range from single survey-consultation to continuing service on a periodic basis. A free copy of the roster may be had by addressing the Society at 221 N. LaSalle St., Chicago 60601.

Dr. Doan in Wrestling Hall of Fame

Dr. John Doan, Decatur, was recently inducted into the Indiana Wrestling Hall of Fame. His involvement in wrestling began when his eldest son, John, was a member of the Decatur High School varsity team in the 1960s. His involvement and interest grew and he was the official doctor for the U.S. World Wrestling team and accompanied them on tour to Iran in 1973. In 1974 he accompanied the team to Turkey for a series of tournaments.

Hyperlipidemia Management Film Offered

"Management of Hyperlipidemia" is the subject of the latest addition to the Ayerst Audiovisual Library. The 16 mm color, sound film has a running time of 30 minutes. Five distinguished physicians contribute to the discussion. It is also available in 3/4 inch videocassette tape. Write for free-loan film or cassette—Ayerst Medical Information Service, 685 Third Ave., New York City 10017.

"How to Live with Gout" Program Offered by Burroughs Wellcome Co.

Burroughs Wellcome Company offers a free patient aid, the "Gout Patient Education Program," consisting of a 7½-minute audio cassette tape and a flip chart. May be used in the doctor's office, in hospital or clinic. Patient instruction booklets are included.

Addiction Services Directory Published

Addiction Medical Education Program (AMEP) of Evansville has published a "Directory of Addiction Services for Southwestern Indiana." Copies may be obtained free of charge by addressing the Program in care of P.O. Box 3287, Evansville 47732.

Six Humanities Seminars Announced

The National Endowment for the Humanities announces continuation of its Humanities Seminars for medical practitioners. Four one-month seminars for physicians and other members of the health professions will be held in the summer and fall of 1977. Two additional seminars, open to health professionals, will bring them together with leaders in law and administration. Up to 15 participants will attend each seminar tuition free and will receive a \$1,200 stipend to cover expenses, plus reimbursement for travel up to a \$300 maximum. William F. May, professor in the Department of Religious Studies at Indiana University in Bloomington, will direct one of the seminars. Application deadline is April 15. Full details and application forms may be obtained by writing Professor William F. May, The Poynter Center, 410 N. Park, Bloomington 47401.

Netherlands Embassy Offers Films

The Royal Netherlands Embassy has a new mini catalog of 15mm free loan films which has just been published and may be obtained free by writing Association Films, 866 Third Ave., New York City 10022. A wide range of topics (38 films in all) is available for showing to travel, tourist or school groups or other organizations.

Diet, Human Behavior Seminars Topic

Allan Cott, M.D., noted psychiatrist and nutritionist, will be featured speaker at a series of seminars on "Health and Human Behavior" during 1977, directed to health and medical professionals, educators and parents. Presented during the year in three major cities, Atlanta, Indianapolis and New York, the seminars are co-sponsored by Advances in Instruction, a division of the School Curriculum and Instruction Group of Harcourt Brace Jovanovich, Inc. and the American School Health Association.

Widely known through the health and medical professions for his work in the treatment of schizophrenia, learning disabilities and behavioral disorders through the use of dietary supplements, Dr. Cott is the author of numerous books and articles on the use of vitamins, mega-vitamins, minerals and acids.

The Indianapolis meeting will be at Stouffers Inn, July 22 through 24. Information and registration forms from Advances in Instruction, Room 2405, 757 Third Ave., New York City 10017.

New Standards, Manual Available From Fire Protection Association

The National Fire Protection Association has new standards for Respiratory Therapy and Hyperbaric Facilities and a "Manual for the Home Use of Respiratory Therapy." The item numbers are respectively 56B, 56D and 56HM. Prices are \$2.25, \$2.50 and \$2.25. The address is 470 Atlantic Ave., Boston 02210.

Lilly Company President Retires

Thomas H. Lake, president of Eli Lilly and Company, retired Dec. 31. He will continue as a Lilly director and will serve as vice-chairman of the board. Richard D. Wood, chairman of the board, will also serve as president.

University Cooperates in Research

Loma Linda University is one of five institutions in the U.S. to participate in a six-year-long cooperative research

project to determine the effectiveness of intermittent positive pressure breathing. Since the treatment is expensive, and since a large series of patients with matched controls has been reported to not demonstrate any clinical advantages, the proposed study should be welcomed.

Continuing Medical Education

The following Indiana physicians are recent winners of the coveted AMA Physician's Recognition Award:

- | | |
|---|--|
| Charles M. Acton, Terre Haute | Richard R. Horning, Logansport |
| Howard M. Addis, South Bend | Neil E. Irick, Indianapolis |
| Daniel J. Ahearn, Indianapolis | Mikhail F. Jeha, Munster |
| Justin E. Arata, Fort Wayne | John E. Joyner, Indianapolis |
| Cesar S. Archangel, Jeffersonville | Philip E. Kellar, Hobart |
| Shahid Athar, Indianapolis | Robert M. Kelsey, LaPorte |
| Charles H. Aust, Fort Wayne | Ernest L. Knight, Elkhart |
| Thomas V. Ballantine, Indianapolis | Forrest R. La Follette, Hammond |
| Charles Baran, South Bend | Edward M. Lai, Terre Haute |
| Elmer A. Barron, East Chicago | Thomas F. Lavelle, South Bend |
| Harold G. Benedict, Anderson | Efren R. Lopez, Vincennes |
| Larry G. Bond, Lafayette | Bernard Lourie, Evansville |
| James H. Booze, Bloomington | Jovencio P. Mangahas, Hammond |
| William C. Brennan, Highland | Lester M. Mason, Terre Haute |
| Edward G. Bryant, East Chicago | Victor P. Matibag, Jeffersonville |
| George E. Bullington, Franklin | Robert K. Mc Kechnie, Jeffersonville |
| Joyce E. Byllesby, Crawfordsville | Walter M. Mikulaschek, Indianapolis |
| Pelayo B. Cabrera, Crown Point | Felix Millan, Munster |
| Mary E. D. Carroll, Crown Point | Donald C. Miller, Cedar Lake |
| Rechad M. Cassim, Elkhart | Robert J. Milos, Merrillville |
| Felipe S. Chua, Munster | Robert J. Nichols, Vincennes |
| Hymen L. Cohen, Gary | James T. Oswalt, Bedford |
| B. Trent Cooper, Roanoke | Dineshchandra A. Patel, Munster |
| John F. Cooper, Muncie | Robert R. Penkava, Evansville |
| Ali A. Daftary, Batesville | Howard A. Pope, New Albany |
| Gerald O. Daniel, Anderson | Gene E. Ress, Tell City |
| David J. Dietz, Muncie | Norman F. Richard, Angola |
| Jerome F. Doss, Kokomo | Robert E. Rose, Spencer |
| William N. Ellis, Indianapolis | Lois A. G. Scheimann, Valparaiso |
| Bernard J. Emkes, Indianapolis | Alan D. Schmetzer, Indianapolis |
| Philip C. Ferguson, Wabash | Carlos A. Serna, Highland |
| John L. Ferry, Hammond | Philip O. Shriner, Fort Wayne |
| Max L. Fields, Monticello | Clifford J. Sondgerath, West Lafayette |
| Eleanor H. M. J. Filmer, West Lafayette | Adam C. Stevens, Kendallville |
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| Luis N. Galup, South Bend | Charoen Suwanwilai, Griffith |
| Medhat H. Girgis, Bedford | Kirby B. Tarry, Columbus |
| James E. Gluckin, Elkhart | Rohan L. M. Tiruchelvam, Marion |
| Joe S. Greene, Bluffton | Lau Tran, Lyons |
| James U. Guthrie, Peru | Laverne B. Tubergen, Indianapolis |
| Henry A. Hadidian, East Chicago | Teofilo S. Vinluan, Marion |
| Ronald C. Hamaker, Carmel | Jack G. Weinbaum, Terre Haute |
| Robert E. Hannemann, Lafayette | Laurel J. Woerner, Indianapolis |
| Ralph J. Harvey, Zionsville | Rosario C. Yaptinchay, Marion |
| Stephen D. Hathway, South Bend | Stanley G. Zallen, Hammond |
| Thomas E. Hayhurst, Fort Wayne | |
| Claude J. Heritier, Columbia City | |
| Edward L. Hollenberg, Winamac | |

Schedule for Upcoming NCME Programs

The Network for Continuing Medical Education Announces the following schedule of programs:

April 4-17 "BRONCHIAL ASTHMA: NEW CONCEPTS IN MECHANISMS AND MANAGEMENT," with Jay A. Nadel, M.D., physiology and radiology chief, Chest Service, Cardiovascular Research Institute, University of California, San Francisco.

"MEDICO-LEGAL ASPECTS OF CPR," with Kevin M. McIntyre, M.D., professor of medicine, Harvard Medical School and assistant chief of cardiology, W. Roxbury Veterans Administration Hospital, Boston.

"THE RATIONAL USE OF ANTIBIOTICS IN SURGICAL PATIENTS," with Richard H. Parker, M.D., chief, Section of Infectious Diseases, Veterans Administration Hospital, Washington, D.C.

April 18-May 1 "THE CYANOTIC INFANT: FINDING THE CAUSE" and

"CYANOTIC HEART DISEASE IN INFANTS," with Richard J. Golinko, M.D., Director of Pediatrics and Pediatric Cardiology, The Brookdale Hospital Medical Center in Brooklyn, N.Y.

"CORTICOSTEROID THERAPY AND INFLAMMATORY BOWEL," with John V. Corbone, M.D., professor of medicine, and director of student teaching, Department of Medicine, University of California, San Francisco.

May 2-15 "SYSTEMIC MYCOSES: HOW TO SELECT AND INTERPRET THE TESTS," with John E. Bennett, M.D., head of the Clinical Mycology Section, Laboratory of Clinical Investigation, National Institute of Allergy and Infectious Disease, Bethesda, Md.

"HYPERTENSIVE EMERGENCY WORKSHOP," with Harriet P. Dustan, M.D., President, American Heart Association, and Vice-Chairman of the Research Division, the Cleveland Clinic Foundation; Edward D. Frohlich, M.D. Head of the Section on Hypertensive Diseases, Ochsner Clinic, and Vice-President for Education and Research, Alton Ochsner Medical Foundation, New Orleans; and Gerald E. Thomson, M.D., Director of Medicine at Harlem Hospital Center and Professor of Medicine, Columbia University College of Physicians and Surgeons, New York City.

May 16-29 "OVARIAN CANCER: THE AGGRESSIVE DIAGNOSIS" and

"OVARIAN CANCER MANAGEMENT: THE PLANNED ATTACK," with Hugh R. K. Barber, M.D., clinical professor and director of obstetrics and gynecology at Lenox Hill Hospital, attending surgeon of the Division of Gynecology of Memorial Hospital, New York City, and president of the New York City Division of the American Cancer Society.

"GAIT: NORMAL AND ABNORMAL," with Robert S. Siffert, M.D., professor and chairman, Department of Orthopedics, Mt. Sinai Hospital, New York City.

Color Film "The Sea Within Us" Offered

Searle Laboratories announces a new medical education program entitled "The Sea Within Us," which consists of a 25-minute, 16 mm color film dealing with electrolyte balance and

the various disease mechanisms associated with hyponatremia. The film has been awarded The John Muir Memorial Hospital Medical Film Festival Award for excellence. Monographs in sufficient number are furnished for the audience. Address requests for free loan of the film and a supply of monographs to Searle, P.O. Box 5110, Chicago 60680.

Clinic Celebrates 60th Anniversary

The 60th anniversary of the founding of the South Bend Clinic occurred recently. Founded in 1916 by six physicians, the clinic has increased to 30 doctors in a number of medical and dental specialties today. An expansion of the facility is under construction.

Aviation Medics Elect Dr. Goldstone

Dr. Sidney R. Goldstone, Munster, was recently elected president-elect of the Civil Aviation Medical Association. He will head the organization of aviation medical examiners who define the basic mental and physical requirements for civil airmen and determine and disseminate other public safety policies.

Letter

to the editor

To the editor:

You were kind enough to print my "A Farewell to Obstetrics" last year—and something like that just encourages an amateur! Thus . . .

THE SECOND 50 YEARS

To an aging old doctor one thing is clear—
The work and worries grow harder each year;
The nighttimes are darker, the sunshine is
brighter;
While workdays seem longer, the patient
load is lighter.
Old friends whom you've cared for have
crossed the Styx;
New faces seem distant, or bland or betwixt.
The love of the work grows as each day
unfolds,
But so does the dread of what each work-
day holds.
Some tomorrow will end the work we had
begun,
And, at last, our turn will come as His will
be done.
We'll glide to that place to await His next
call
And hope that by His choice, again do it all—

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Deaths

Donald D. Cheesman, M.D.

Dr. Donald D. Cheesman, 41, Danville, died Feb. 11 in Hendricks County Hospital.

Following his graduation from the Indiana University School of Medicine in 1960, he interned at Marion County General Hospital, and then served with the U.S. Public Health Service, Division of Indian Health, at Gallup, N.M. for two years. In 1963 he entered private practice at Danville.

Dr. Cheesman was a member of the Hendricks County Medical Society and the American Medical Association.

Chester C. Conway, M.D.

Dr. Chester Conway, Indianapolis, died Feb. 26 in Community Hospital at the age of 72.

He graduated in 1936 from the Indiana University School of Medicine and had been in general practice in Indianapolis until he retired last August.

Dr. Conway was on the staff of Community Hospital and was a member of

the Marion County Medical Society and the American Medical Association. In 1975 he became a Senior Member of the Indiana State Medical Association.

Richard M. Laycock, M.D.

Dr. Richard Marshall Laycock, Fort Wayne, died Jan. 8 in the emergency room of Parkview Memorial Hospital. He was 45.

He graduated from Indiana University School of Medicine in 1957 and interned at Deaconess Hospital, Spokane, Wash., following which he returned to Fort Wayne to practice.

On the staff of Parkview Memorial Hospital, Fort Wayne, Dr. Laycock was a member of the Allen County Medical Society and the American Medical Association.

Norman S. Loomis, M.D.

Dr. Norman S. Loomis, retired Indianapolis surgeon, died Jan. 21 at Boca Raton, Fla., where he had lived since retirement in 1958. He was 79.

He was a graduate of Indiana University School of Medicine in 1929, elected to membership in 1932, and practiced in Indianapolis.

A member of the Marion County Medical Society and the American Medical Association, he was eligible for Senior Membership in the Indiana State Medical Association in 1969.

C. O. McCormick, Jr., M.D.

Dr. Charles Owen McCormick, Jr., 62, Indianapolis, died at home Feb. 20. A 1938 graduate of the Indiana University School of Medicine, Dr. McCormick practiced in Indianapolis and had been on the Community Hospital staff since it was founded. During World War II he served with the U.S. Army in England, Africa and Italy.

Dr. McCormick was a member of the American College of Obstetricians and Gynecologists and the American College of Surgeons. He was also a member of the Marion County Medical Society and the American Medical Association.

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3935 N. Meridian St., Indianapolis 46208.

From THE JOURNAL 50 Years Ago

The many reports of rapid restoration of vision, following operative measures on the posterior group of sinuses strongly suggest that every case of failing vision not due to intra-ocular disease should receive a most searching examination for the purpose of determining whether or not the nasal accessory sinuses are the primary seats of the infection. The mere fact that blindness exists is not, however, a positive indication for radical surgery on the sinus which is presumed to be the primary focus of the disease. Before operation is undertaken in any case a very complete examination of the general system, of the eye, and of the central nervous system as well as the sinuses should be made. Complete investigation may reveal the fact that the progressive loss of vision is caused by a cerebral tumor, an enlarged pituitary gland or by the presence of some general disease, in which case, of course, any operative attack on the nasal sinuses would be contraindicated. . . . John F. Barnhill, M.D., Indianapolis, "Relation of Infected Nasal Sinuses to Optic and Orbital Disease," JISMA, April 1927.

COMMERCIAL ANNOUNCEMENTS

PHYSICIAN WANTED to take over at no charge well established general practice in college town (DePauw University) in central Indiana in July. One hour's drive from Terre Haute, Bloomington, Indianapolis; in progressive farming community. Practice grosses \$100,000 without OB. Space is rented but there is equipment and office furniture for sale. Call or write and then visit Greencastle to look over community and hospital facilities and meet medical staff and prospective patients. R. M. Jacobs, M.D., Box 546, Greencastle, IN 46135 (317) 653-3206.

NEW BUILDING being built at 4543 Lafayette Road, near Lafayette Square shopping center. Also space in Clermont, Ind. D. E. Tavel, 293-5424.

OTOLARYNGOLOGIST and Physical Medicine Rehabilitation, trained at McGill University, seeking relocation in Indiana. Write Box 413, The Journal, 3935 N. Meridian St., Indianapolis 46208.

EXCELLENT OPPORTUNITY and environment—physician needed to practice general medicine in large outpatient clinic and 38-bed fully accredited hospital. Must possess empathy toward college age population. Salary negotiable, excellent fringe benefits. Contact L. W. Combs, M.D., Purdue Student Hospital, West Lafayette, Indiana 47907. 317-749-2441.

Equal access/equal opportunity employer

BAUSCH & LOMB microscope, monocular, 3 obj's, \$250. Dr. Kays: 812-476-2124.

RETIRING INTERNIST desires replacement for large practice in excellent medical community with superb colleagues, hospital, laboratory and x-ray facilities. Will introduce. Practice available anytime this summer. Call or write Dr. Richard W. Holdeman, 404 N. Lafayette Blvd., South Bend, IN 46601; telephone 1-219-232-1291.

EXCELLENT OPPORTUNITY for physician desiring regular hours and ideal working conditions. Basic responsibilities are in the Medicaid Division and in the Public Assistance Division of the State Department of Public Welfare to review applications for assistance to the disabled. Enjoy a competitive salary and many fringe benefits. Please contact James O. Price, M.D., Indiana State Department of Public Welfare, telephone 317-633-5596.

PHYSICIAN OPENING IN INDIANA REHABILITATION SERVICES INDIANA REHABILITATION SERVICES has openings for physicians in its various divisions. Interested persons should contact Dr. Walter E. Deacon, #1016 Illinois Building, 17 West Market Street, Indianapolis, Indiana, Telephone: 317-633-5961.

WANTED-PSYCHIATRIST to direct the Mental Hygiene Clinic at VA Outpatient Clinic in Evansville, IN. Beginning salary up to \$45,000 depending on qualifications. 30 days vacation, 15 days sick leave, educational opportunities and many benefits. Licensed in any State. An Equal Employment Opportunity employer. Contact Chief Medical Officer, VA Outpatient Clinic, Evansville, Indiana 47708. Telephone: (912) 423-6871.

CONFERENCES for Medical Professionals—A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialties included. Send a \$10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

WANTED: PHYSICIAN FOR STUDENT HEALTH CENTER. Excellent facility including laboratory, x-ray and pharmacy. Position available July 1, 1977. Must be licensed to practice in the state of Indiana. Applications received after June 1, 1977, may not be considered. Contact John A. Hetherington, M.D., Director Student Health Center, Indiana State University, Terre Haute, Indiana 47809. Phone: 812-234-2646. ISU is an Equal Opportunity/Affirmative Action Employer.

DOCTOR: YOU CAN CASH IN the equity in your home—without moving or borrowing! Send for free details. CASH, Box 40215-M3, Indianapolis 46240.

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FAMILY PHYSICIANS-INTERNISTS-OB/GYN, certified or recently eligible—for large midwest multispecialty group. Competitive first year salary with opportunity for early Partnership. All fringes Clinic paid—most liberal Vacation and PG allowance. Excellent laboratory and up-to-date diagnostic radiology equipment. Every opportunity to develop your own practice. Send CV to: Thomas R. Hofferth, Hammond Clinic, 7905 Calumet Ave., Munster, IN. 46321; (219) 836-5800.

FOR RENT—Luxuriously furnished 2-bedroom condominium at The Pointe on Lake Monroe. Fish, swim, boat, ski, golf, tennis, deck tennis. Sleeps six; 2½ baths; air conditioned; \$275 per week, \$55 per day. Call 317-844-8570 after 7 p.m.

OFFICE SPACE for lease—Dermatologist retired from active practice. Seven rooms unfurnished. Close to Community Hospital, Indianapolis. Contact 317-356-6087.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be consid-

ered for display type advertising.

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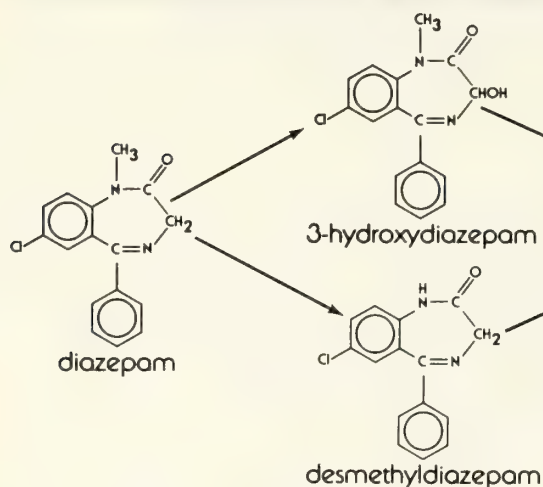
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to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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MEDICAL MUSEUM NOTES



William Baldwin Fletcher, M.D., was a founder of the Indiana Medical College in 1869. When lectures to medical students were first established in the Old Pathology Building in 1896 he was one of its four original teachers. (The others were Drs. Frank Wynn, Albert E. Sterne and Ernest Ryer.) Dr. Fletcher's portrait now hangs in the amphitheater where he taught.

Dr. Fletcher was born in Indianapolis Aug. 18, 1837. From his father, Calvin Fletcher, he acquired a love of nature which was fostered

by the rural setting of pioneer Indianapolis. In 1855 he went East and became a pupil of the great naturalist, Louis Agassiz.

Jean Louis Agassiz (1807-1876) was born and reared in a small Swiss village (Motier-en-Vully). He entered the University of Bienne at the age of 10, and the College of Lausanne at the age of 12. He entered the University of Heidelberg and later the University of Munich. He had both the M.D. and Ph.D. degrees, and had a well-established reputation in Europe as a naturalist by age 25. His interests were broad, and his talents were many.

In 1846 Agassiz came to America and became a professor of zoology and geology at Harvard University. His crowning achievement was establishing and developing Harvard's Museum of Comparative Zoology.

Agassiz had been nine years at Harvard and was almost 50 when young Fletcher, then 18, came under his tutelage.

Fletcher completed a year with Agassiz, who remained a life-long

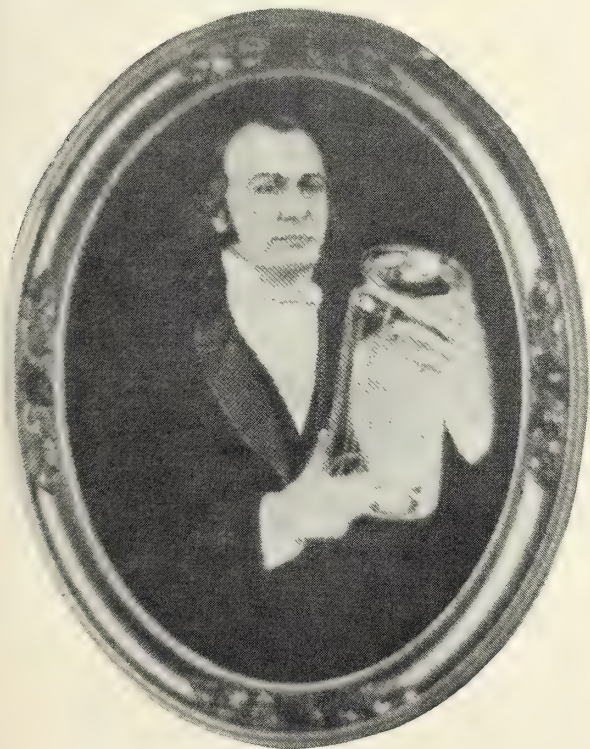
influence, then went on to the New York College of Physicians and Surgeons, where he studied from 1856 to 1859. After receiving his M.D. degree Dr. Fletcher returned to Indianapolis.

Following the war, Dr. Fletcher obtained a postgraduate medical education in Europe and then returned to Indianapolis to practice. He was 32 years old when he participated in the founding of the Indiana Medical College in 1869.

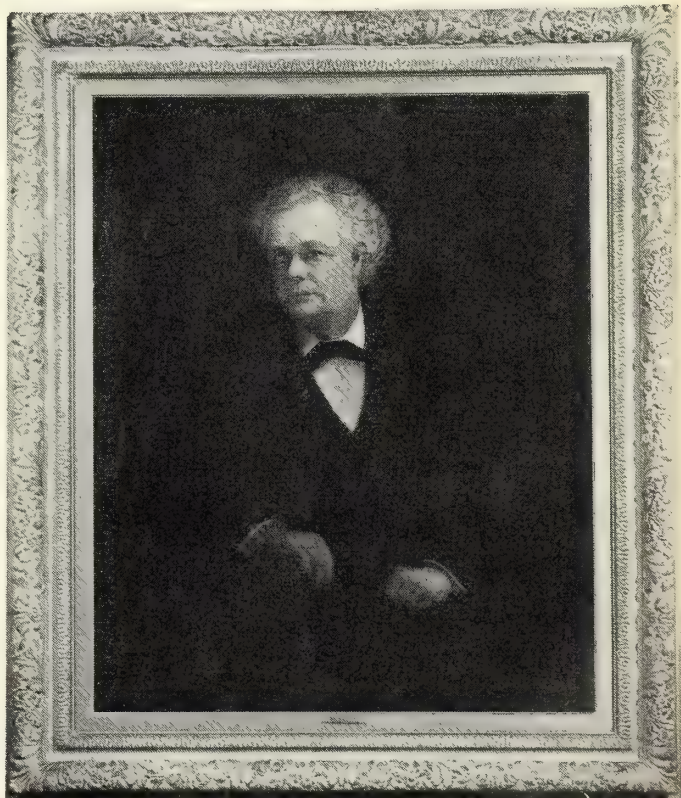
The portrait of Dr. Fletcher was done by T. C. Steele in appreciation for Fletcher's substantial contribution to Steele's European training.

The Museum has recently acquired three large handblown specimen jars from the Agassiz Museum. These handblown jars (two to three feet tall) were made by the New England Glass Company for Dr. Agassiz and were used for more than a century in the Museum of Comparative Zoology.

CHARLES A. BONSETT, M.D.
6133 E. 54th Place
Indianapolis 46226



PORTRAIT of Louis Agassiz holding handblown specimen jar such as the Museum acquired recently.



PORTRAIT of Dr. William B. Fletcher by T. C. Steele, now in Museum Amphitheater.

Letters

April 7, 1977

The President of the United States
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Carter:

As March ended the normal influenza season in the United States, the Indiana State Medical Association (ISMA) would like to bring your attention to its opinion on two issues. One involves the National Influenza Immunization Program of 1976 and the other is the proposed National Immunization Program of your administration.

The executive and legislative responsibility for the National Influenza Immunization Program was a mistake for which we all must share some measure of responsibility. Although the ISMA never fully endorsed the swine flu program, it was supported by most medical organizations in the United States. It was called a tragic error by eminent epidemiologists and a mistake of federal bureaucrats by members of Congress, with which the ISMA is in full accord.

The influenza program which increased the cost of the simple flu flu shot two to threefold was an inflationary act of legislation. It was an example of government interference in direct patient care that, hopefully, will not be repeated.

In our letter to the HEW Secretary dated July 23, 1976, we requested that: (1) influenza vaccine formulation for 1976-77 remain unchanged (bivalent: A/Victoria, B/Hong Kong) and marketed through commercial channels as it had been for the past 30 years, and (2) only swine influenza (A/New Jersey) be purchased by the government for storage, but distributed through private sector channels to existing public and private systems of a continuing doctor-patient relationship if medical proof of such an epidemic disease was confirmed. The validity of this request, supporting the doctor who is the nation's primary health care provider, is now obvious.

The issue of the new National Immunization Program cannot be supported by ISMA. The private sector of medicine, with the assistance of state and county medical societies, has already demonstrated its ability to control epidemic disease in Indiana. Paralytic poliomyelitis and congenital rubella syndrome in this post-vaccine era are essentially eradicated in this state, and smallpox is eradicated. Data do not support a probability for epidemic disease with any childhood communicable disease in Indiana.

To repeat a similar national immunization program would be another inflationary act of legislation and would create a similar cost increase to the consumer. It would be contrary to our endorsement of the concept that all immunization programs should be a part of, or an introductory link to, a continuing

doctor-patient relationship.

During 1976 Indiana was one of the last states to require immunization for a child entering school for the first time. Only Idaho, Wyoming and Iowa do not have such state legislative acts. Last fall, non-immunized children entering the first grade in Indiana varied from 5% for polio to 10% for measles. This low percentage of susceptibles is an exemplification of the quality of the nation's primary health care provider—the doctor.

The ISMA supports the actions taken by the Indiana General Assembly and its physicians and finds no need for an explicit federal immunization program or policy. The national swine flu program was a bad precedent and an excessive waste of money. It was a lesson in government interference in direct patient care, Mr. President, that

INDIANA STATE BOARD OF HEALTH

Division of Communicable Disease Control

School Immunization for Fall 1976

State Enrollment	DPT	Polio	Rubeola	Rubella
Non-immunized children*				
95,673	4.6%	5.1%	9.9%	11.5%

* The effects of the new Indiana law requiring immunizations of children entering school for the first time will not be completely reflected in percentages until the fall of 1977. Population age group: 5-6 years.

Poliomyelitis:

paralytic poliomyelitis pre-vaccine era: up to 20,000/year for the nation

paralytic poliomyelitis post-vaccine era: 6-8/year for the nation (usually vaccine-associated or unavoidable cases)

Rubeola:

encephalitis pre-vaccine era: 1/1,000 or about 4,000/year for the nation

encephalitis post-vaccine era: reduced almost 100%

subacute sclerosing panencephalitis (SSPE) pre-vaccine era: 1/100,000
subacute sclerosing panencephalitis (SSPE) post-vaccine era: 1/1,000,000

(vaccine-associated or unavoidable cases)

Rubella:

pre-vaccine era: epidemics every 8-10 years; last epidemic 1964 produced the Congenital Rubella Syndrome; up to 20,000/epidemic
post-vaccine era: epidemic cannot occur; too few susceptibles
Congenital Rubella Syndrome cases reduced almost 100%

should be prevented in the future.

Sincerely,
JOHN W. BEELER, M.D.
President
Indiana State Medical Association
ROBERT L. PARR, M.D.,
F.A.A.P.
Chairman
ISMA Swine Flu Committee
cc: Joseph Califano, Secretary
Health, Education, and Welfare
Paul G. Rogers
U. S. Representative, Florida
Otis R. Bowen, M.D.
Governor, State of Indiana

To the editor:

Many people who are allergic to aspirin also are allergic to Tartrazine—especially those over 40 with the symptom complex of nasal polyps and asthma. Recent evidence suggests that aspirin sensitivity with or without nasal polyps may be present in children and adults with intrinsic asthma. In fact, some severe asthmatics may be sensitive to aspirin without realizing it.

It has been estimated that 25-80% of those individuals allergic to aspirin are also allergic to Tartrazine (yellow dye FD&C #5), which

is present in some foods, and it is also present in some drugs. Many patients, as well as physicians, are not aware of this.

One such example is the pain reliever Tylenol, which has been used as a substitute for those sensitive to aspirin—because it contains no aspirin, nor any Tartrazine. However, the medication Co-Tylenol does contain Tartrazine. I was made well aware of this fact because of a patient who was referred to me for angiodema and urticaria.

History revealed that aspirin had been taken just prior to the onset of the urticaria and the angiodema. Elimination of the aspirin resulted in the elimination of symptoms. He was given a list of drugs containing aspirin to avoid and also a list of drugs and foods containing Tartrazine. He was told he could use Tylenol.

The patient returned last week with severe angiodema and urticaria. He had not taken any aspirin, but he had taken Co-Tylenol. On the list of drugs I had given him—this was not mentioned. The company which manufactures Co-Tylenol did not give a list of their drugs which contained Tartrazine. A new list has

just come out which does list the drugs containing Tartrazine—Co-Tylenol is one of these drugs. Tartrazine was not listed on the label of the Co-Tylenol as one of the ingredients.

This could cause very severe reactions to someone allergic to Tartrazine—knowing that they could take Tylenol—the similarity of names, Tylenol and Co-Tylenol is very confusing and could be dangerous.

CLAUDE A. FRAZIER, M.D.
Doctors Park, Bldg. 4
Asheville, NC 28801

To the editor:

We would be grateful if you can run the following appeal as a letter to the editor. . . .

For a biography of Dr. Alton Ochsner of Ochsner Clinic, New Orleans, opinions, evaluations, anecdotes, reminiscences, photos are needed. Photos will be carefully handled and returned. All material gratefully received by

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COMING IN JULY . . .

Medicine Grand Rounds, Indiana University
School of Medicine:
Hemophilia

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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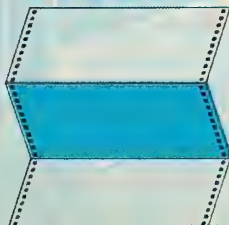
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MONTH IN WASHINGTON

IN THE NAME OF THE "SUNSHINE LAW," the government released the names of physicians, groups and laboratories that did more than \$100,000 in Medicare business last year. It marked the first breach in the Medicare program's long-standing policy against disclosing such information.

The over-\$100,000 category included 409 physicians, 1,752 medical groups and 58 laboratories. This compared to 2,533 physicians, dentists and pharmacies listed in the Medicaid report of more than \$100,000 intake last November.

The American Medical Association branded the releasing of the names as "only serving to badger a large segment of the profession and to establish guilt by innuendo." AMA Executive Vice President James Sammons, M.D., said "there is a basic dishonesty in the broadcast release of the names of individuals receiving Medicare payments." Dr. Sammons added that if "HEW thinks any physician on this list is guilty of fraud, HEW should say so. We will assist in any case where there is good reason to suspect wrongdoing."



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This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

Dr. Sammons said the physicians are identified by HEW as individual recipients of Medicare funds, whereas the payments are often for services provided by many others as well. Many of the physicians listed are hospital-based radiologists, pathologists, anesthesiologists, he said. "We would also point out that these services are paid for at a rate set by Medicare and based on prevailing charges two years out of date."

Predictably, press reaction was uneven. Some press took the trouble to check before using the story. Most press did not. All too typical were headlines like this one, from the Fort Lauderdale *Sun-Sentinel*:

"HEW RELEASES NAMES OF DOCTORS ON MEDICARE GRAVY TRAIN."

Few stories bothered to explain that the figures cited are gross, not net; or that HEW's dollar totals included not only payments to the physician but payments made directly to the beneficiary where the beneficiary is responsible for paying the physician's bill.

Having gone through a similar experience in November of 1976, when the Social and Rehabilitation Service made public a list of physicians, dentists, pharmacies and laboratories that had received \$100,000 or more from Medicaid in 1975, the AMA immediately began checking for accuracy as many as possible of the names and amounts listed as paid to solo practitioners.

By the *Month In Washington* press time, some 166 physicians listed in solo practice were contacted in 30 states and the District of Columbia. Of this group:

- **82 were incorrectly listed as solo practitioners;
- **5 had incorrect amounts attributed paid to them;
- **22 reported both the solo designation and the amount were incorrect.

Some 65.7% of the information released on the 409 physicians listed as solo practitioners was, therefore, incorrect.

Complaints from individual physicians victimized by these inaccuracies poured in to the press. A roundup by the Associated Press pointed out some of the injustices done by HEW release in which two out of three solo practitioners were inaccurately listed.

The Washington *Star* took editorial note of HEW's inaccuracies under the heading: "A SLOPPY PIECE OF WORK."

The physicians contacted by the AMA and state medical societies reported harassment by angry patients, crank telephone calls, children taunted at school as the children of a crook, anonymous threats, attacks by colleagues and continuing embarrassment within their communities.

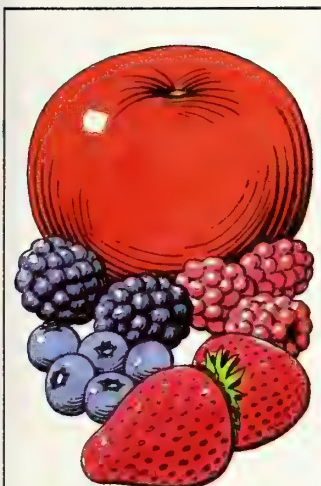
A number of Congressmen have inserted remarks into the *Congressional Record* with respect to HEW's disgraceful performance.

HEW Secretary Joseph A. Califano has privately admitted

Continued on page 229

The **ALLBEE** with C Scrapbook of Vitamin Facts & Fallacies

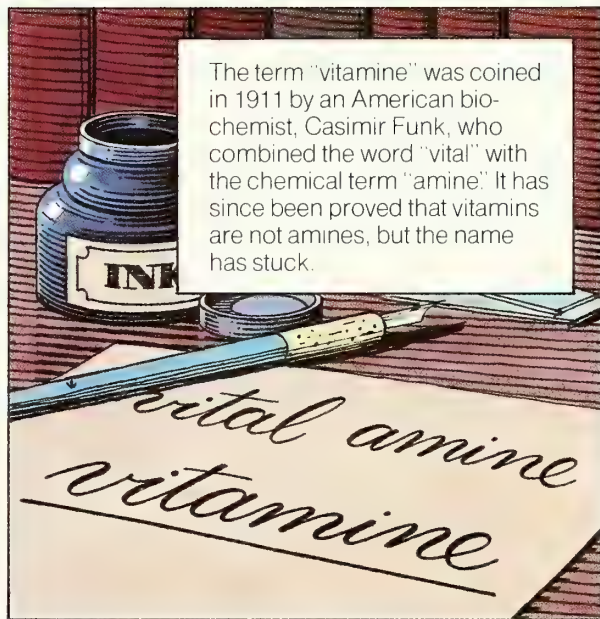
American Indians coveted fresh root tips and extracts of evergreen leaves in winter and onion-like bulbs and leaves in early spring to prevent the symptoms characteristic of vitamin C deficiency.



A tomato is botanically classified as a berry!



It is ironic that many of the vegetables highest in vitamin C and riboflavin are considered unappetizing by many people. These include turnip greens, kale, chard, mustard greens, spinach, water cress, broccoli and brussels sprouts.



The term "vitamine" was coined in 1911 by an American biochemist, Casimir Funk, who combined the word "vital" with the chemical term "amine." It has since been proved that vitamins are not amines, but the name has stuck.



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Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective: adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

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dismay and has publicly stated that a corrected list will be forthcoming shortly.

THE AMA HAS TOLD THE GOVERNMENT that fraud and abuse are different problems deserving different treatment.

In a letter to HEW Secretary Califano, the AMA said: "Frankly, we find it difficult to equate "abuse" of Medicare and Medicaid programs with some legally definable criminal action. Indeed, it is unfortunate that "fraud and abuse" have been linked so often in public discussion and departmental releases that the clearly criminal aspects of "fraud" have migrated to "abuse" as well."

AMA Executive Vice President James Sammons, M.D., said "fraud" is a reasonably well-defined legal concept—misrepresentation with the intent to obtain money or other goods to which one is not entitled—and has always been clearly subject to legal penalties. Dr. Sammons said examples include billing for services not rendered, etc. "The medical profession has always opposed such practices by its members and urges prosecution of those charged with fraud.

However, he wrote, "abuse" is a much more ambiguous term. A "fact sheet" on Medicaid fraud and abuse issued by the Social and Rehabilitation Service states that a provider is "abusing" the program if he files claims and receives payment for services "that are not allowed by federal or state Medicaid laws or regulations." If "abuse" of a program by a provider implies some guilt on his part, this definition is clearly inadequate, since it leaves out any reference to the provider's knowledge of the exclusion, noted Dr. Sammons.

The AMA said the decision as to appropriateness of care "is a professional decision, not a legal one, and we would strongly urge that no attempt be made to bring it within the courtroom, along with prosecution of fraud." Legitimacy and appropriateness of treatment should first be explored by the review committees already established for this purpose at the community level, said Dr. Sammons. "When they agree that the treatment is, indeed, inappropriate and excessive, efforts should be made by his peers to persuade the erring physician to follow a more appropriate course of treatment, but the punitive action should be limited to those already authorized by law—non-reimbursement of excess care and, where the pattern of over-use or over-treatment continues, exclusion of the individual from the program."

He concluded, "We believe that this is both appropriate and sufficient in the way of penalty for actions which the physician himself may consider honest and non-culpable, and we would therefore urge that, while fraud should indeed be prosecuted to the extent of the law, "abuse," in this sense, should be handled within the framework of Peer Review and program administration controls."

TO COUNTER CHARGES THAT HIS DEPARTMENT has been lax in cracking down on fraud and abuse in health programs, HEW Secretary Califano has called in the FBI.

He said FBI agents will work "full blast" on Medicare and Medicaid misdoings until HEW's own office of investigations is "up to full speed."

Califano made the statements following a report by the Senate Special Committee on Aging contending that illegal kickbacks are "rampant" in the Medicaid program. Summarizing testimony given the Committee last year, the report said nursing homes are the chief offenders, but "increasing evidence points to hospitals, medical practitioners, clinical laboratories and other suppliers."

Not making Califano's life any easier was an allegation by John Walsh, former director of HEW's Office of Investigations, that the new HEW secretary and his under-secretary designate,

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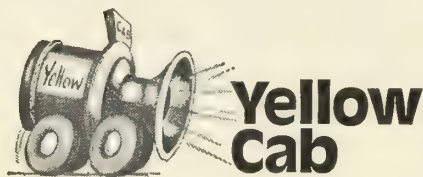


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Continued

Hale Champion, tried to impede an investigation of fraud in a San Jose, California, Medicaid project. Walsh, who resigned his post, said he was told he had to clear the investigation with his superiors. Califano and Champion angrily denied they were in any way attempting to influence the course of the probe.

"I did not in any way hinder or impede our fraud investigation—nor did Mr. Champion—in California or elsewhere," Califano said on NBC's Meet the Press program. "Everything that I've done in this area has been designed to make those investigations go faster and better."

THE WEIGHT OF SCIENTIFIC EVIDENCE points to a relationship between television violence and increased aggressive behavior in some youthful viewers, the AMA has told Congress.

The AMA called on the TV industry to recognize its social responsibilities, to reduce the amount of violence and to respond with greater sensitivity and diversity in its programming policies. "That television violence represents a serious issue in the mind of the public is a consideration the broadcasting industry can no longer ignore," declared Robert Stubblefield, M.D., consultant on mental health matters to the AMA.

THE NEW COMMISSIONER OF THE FOOD AND DRUG ADMINISTRATION is Donald Kennedy, Ph.D., a neuro-physiologist from Stanford University. Dr. Kennedy is the first non-physician to head the agency in 11 years but he doesn't place much significance in that fact.

HEW Secretary Califano praised Dr. Kennedy in announcing the appointment and said "it is imperative that the FDA act only in the public interest and with much greater dispatch than it has in the recent past."

CHRISTOPHER C. FORDHAM, M.D., dean of the University of North Carolina Medical School, is the choice of the Carter Administration as assistant secretary for health at HEW.

The naming of the federal government's top health official had been the subject of much speculation and interest over the past weeks. The selection of the assistant secretary for health (ASH) in a new Administration is considered an important guide to the type of health policies HEW will pursue.

Dr. Fordham, 49, is a board certified internist and a member of the AMA. He received his medical degree from Harvard University Medical School. He is well-known in North Carolina and is regarded generally as a moderate on socioeconomic medical issues.

THOMAS D. MORRIS, a member of the senior staff of the Brookings Institution, was named to the newly created post of inspector general of HEW.

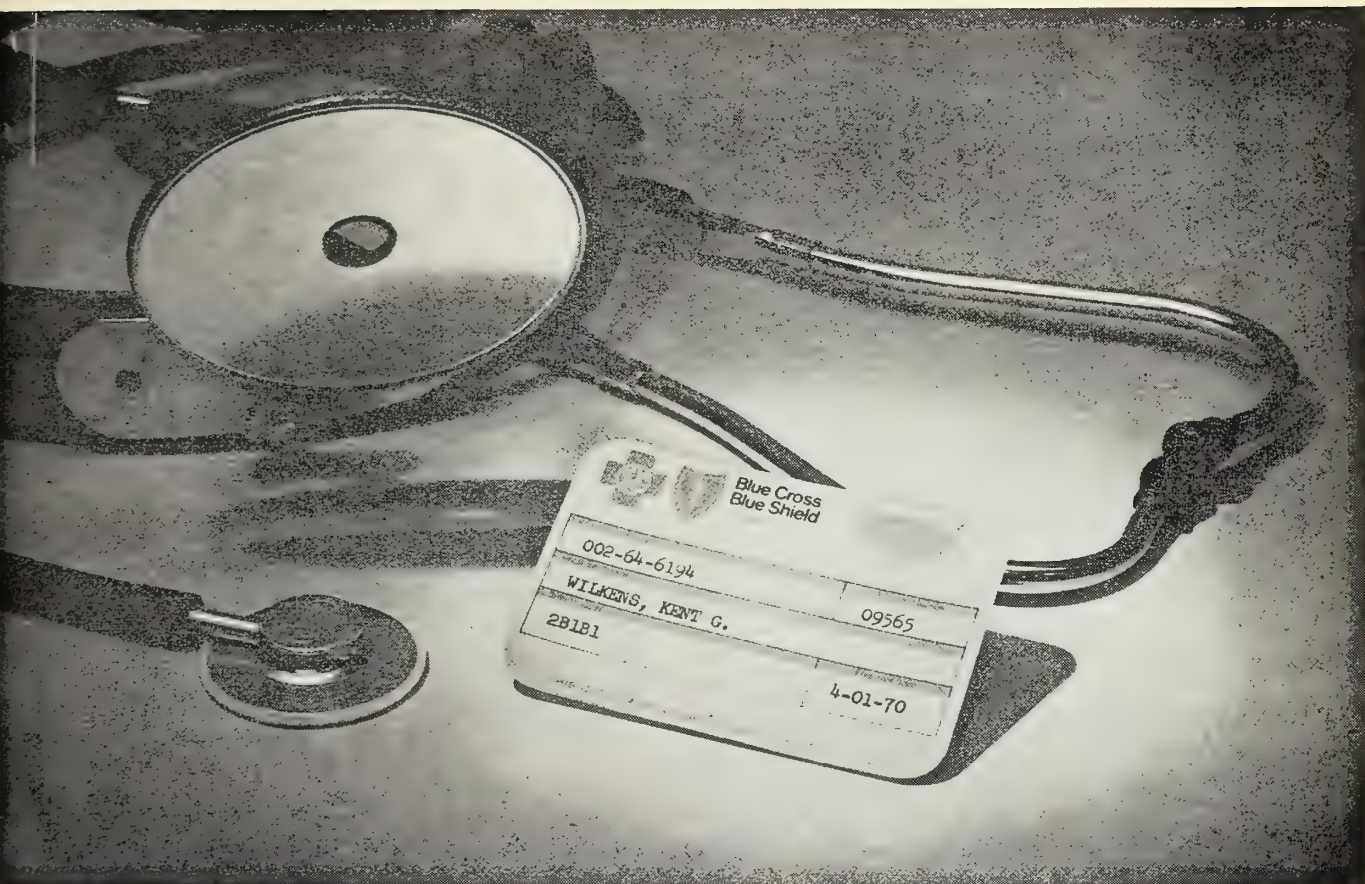
The job was established by Congress last year to oversee a \$25 million program, to find fraud and abuse in various HEW programs, especially Medicaid. Morris will have a staff of 1,000 auditors and 100 investigators.

Morris, 63, was assistant secretary of defense in charge of the cost reduction program and procurement operations from 1961 to 1968 and was assistant comptroller general from 1970 to 1975. For the past year, he has been a senior staff member of the Brookings Institute in Washington.

Morris will focus initially on the broad area of health-care services, including alleged widespread fraud in the Medicare and Medicaid programs, and the student loan programs.

Morris will be responsible both to the HEW secretary and to Congress. The importance of the post was underlined by having the announcement of Morris' appointment come from the White House rather than the secretary's office. ◀

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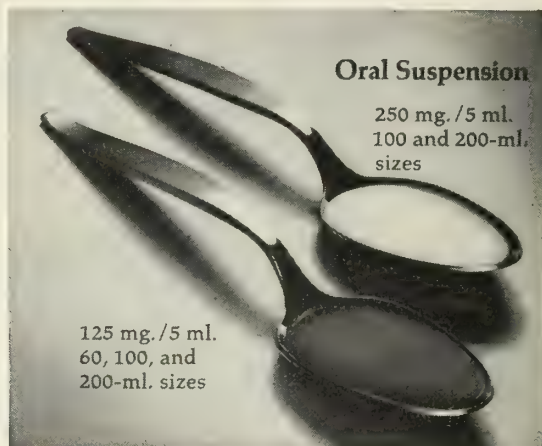
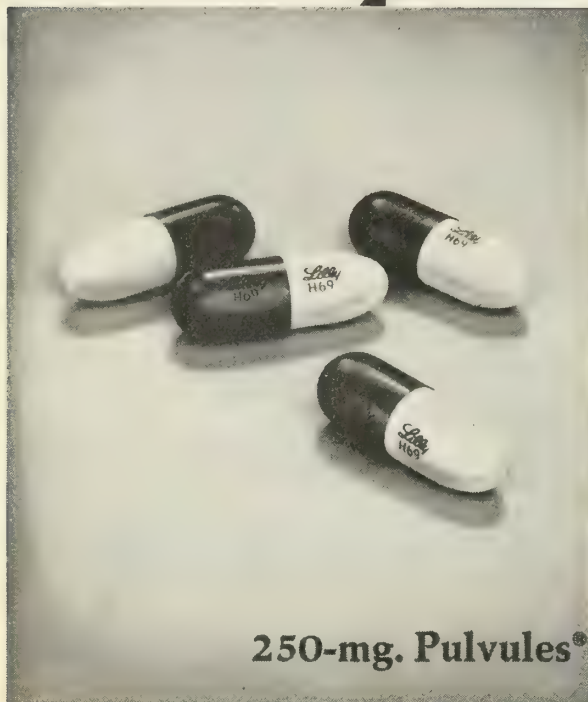
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Arteriovenous fistulization, as a result of a surgical procedure, is rare. It is a wonder that it does not occur oftener. This one, due to accurate diagnosis and careful repair, has had a happy ending.

Iatrogenic Fistula of the Gastroduodenal Vessels

J. BRADLEY THURSTON, M.D.
MICHAEL F. MILAN, M.D.
FREDERICK G. WINEGARNER, M.D.

Indianapolis

ARTERIOVENOUS fistulas have been reported following a variety of surgical procedures from venipuncture to colon resection. Systemic portal arteriovenous fistulas are rare; review revealed only 20 previous reports in the English literature and only one previous report involving the gastroduodenal artery and vein. This case is of interest in that the patient tolerated his fistula for more than 10 years without symptoms or development of portal hypertension in spite of a high flow state. Diagnosis prior to laparotomy made possible a thorough evaluation of the effects of the fistula preoperatively, intraoperatively and postoperatively.

Case Report

Mr. G. A. is a 53-year-old black male admitted to the Indianapolis Veterans Administration Hospital for evaluation of hypertension and a buzz in his abdomen, both of which had been present for 10 years. He had had an emergency partial gastrectomy with a Bilroth II anastomosis and vagotomy for a bleeding

duodenal ulcer 22 years prior to admission. He had had no ulcer symptoms since his initial surgery; however, he did develop a mild dumping syndrome, but he had maintained a stable weight. Twelve years prior to admission he underwent an abdominal exploration for lysis of adhesions and bowel obstruction. Postoperatively, he was noted to have a loud abdominal bruit, which was not further investigated.

His physical examination was unremarkable with the exception of mild hypertension (150/90) and a loud, continuous machinery-like bruit in the right upper quadrant, which radiated throughout the entire abdomen and could not be obliterated by abdominal manipulation. Pertinent laboratory tests included normal creatinine clearance, V.M.A., amylase, total proteins, albumin, calcium, phosphorus, urinalysis, electrolytes, bilirubin and serum creatinine. His SGOT, LDH, CPK and alkaline phosphatase were all mildly elevated. Protime, partial thromboplastin time, arterial and venous gases and complete blood count were within normal limits. Examination of his peripheral smear with differential and platelet count

was normal. Although his electrocardiogram was normal, his cardiac output (6.9 L/min), cardiac index (3.6 L/min/m²) and blood volume (6.26) were significantly elevated. A transfemoral selective arteriogram of the celiac axis revealed an enlarged common hepatic artery, which flowed into the gastroduodenal artery, which again was enlarged and tortuous with 1.5 cm aneurysm at its base and a fistula at the tip to an enlarged vein which drained directly into the portal vein. No arterial blood flow was seen to the liver, but this was thought to be secondary to shunting through the low-resistance fistula.

The fistula was readily identified at operation both by palpation and identification of the dilated vein. It was found to contain a single artery and vein of approximately 15 cm in length. No branches were noted from the fistula back to the origin of the artery and vein. The artery was traced back to its junction with the hepatic artery, and a 2 cm aneurysm was identified near its origin. The arterial diameter, by direct measurement, was 9 mm, and the vein diameter 15 mm. Doppler flows taken intraoperatively were found to

From the Department of Surgery, Indiana University School of Medicine, Indianapolis 46202.



FIGURE 1

Early phase oblique arteriogram showing a dilated gastroduodenal artery arising from the hepatic artery. Early venous filling is evident. Fistula is indicated by arrow.



FIGURE 2

Late venous phase showing massively dilated vein. Note the small aneurysm of the gastroduodenal artery at its midpoint.

be 300 ml per minute in the artery and 305 ml per minute in the vein. Portal pressure of $7.5 \pm .5$ cm of water was recorded directly through the portal vein. This pressure did not change with occlusion of the fistula. The fistula was resected by simple ligation of the base of the artery and vein separately. Liver biopsy, jejunal biopsy, incidental cholecystectomy and resection of an omental granuloma were also performed. The jejunal and liver biopsies were read as essentially normal.

One year postoperatively Mr. G. A. is asymptomatic, without symptoms of dumping, and has been able to gain weight for the first time in 10 years.

Discussion

Mesenteric arteriovenous fistulas are relatively rare and have been appreciated only recently with the advent of angiography. Lack of symptoms often makes the diagnosis difficult without radiologic confirmation. Our patient had minimal symptoms related to his fistula, although, in retrospect, his dumping-like symptoms may have been secondary to the fistula. The literature shows frequent symptoms to be: postcebal fullness, abdominal distension, diarrhea, cramping, pain, fatigue, dyspnea, chest pain, fever, weight loss, palpitations, gastrointestinal hemorrhage and a buzzing feeling in the abdomen. In contrast, arteriovenous fistulas in the systemic circulation are more symptomatic. Frequently, with associated cardiac decompensation, they are more easily diagnosed by (1) a continuous thrill and bruit over the fistula, (2) elevated venous pressure and appearance of venous congestion distally, (3) a rise in diastolic pressure and a drop in pulse rate when the fistula is occluded by direct manual pressure (Branham's sign), (4) growth disturbances of the affected limb and (5) arteriography.

Unfortunately, when the fistula lies deep in the abdomen, palpation, measurement of venous flows and pressures and direct observation of the involved vessels require laparot-

omy. The systemic signs caused by portal A-V fistulas are often not present. This is thought to be a result of the buffering action of the liver. Indeed, Branham's sign was negative in our patient intraoperatively. However, the presenting symptoms are often the result, in counter distinction to peripheral fistulas, of the increased pressure in the portal system evidenced by an irritable bowel, and development of portal hypertension with hepatportal sclerosis. Interestingly, our patient tolerated his fistula for greater than 10 years without any changes suggesting liver disease or portal hypertension. This may be due to the fact that his fistula had too low a flow to increase his portal pressure. Presumably, a high enough flow rate could increase portal pres-

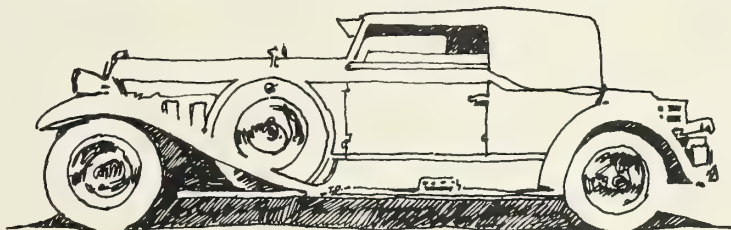
sure significantly with the resultant complication of portal hypertension. With the liver acting as a buffer, increased venous return to the heart is seldom great enough to cause cardiac symptoms, although our patient did have slightly elevated cardiac output, cardiac index and blood volume. These reverted to normal with repair of his fistula. He did not have any cardiac symptoms.

One etiology of postsurgical arteriovenous fistulas has been thought to be the ligation of an artery and vein in a single tie. Certainly this does not always result in fistulous formation, or there would be more than 20 previous case reports. Gilbert implicates infection as a contributory factor, and indeed our patient had abscess formation, as evidenced by a granuloma in the mes-

entary. The resected fistula in our patient had a long stalk with a communication at the tip of a blind artery and vein appearing as if the two vessels had indeed been incorporated into a single suture ligature.

Surgical repair is indicated to prevent development of portal hypertension with gastrointestinal bleeding, cardiac decompensation, gastrointestinal symptoms and bowel ischemia from shunted flow or gross hemorrhage from rupture of the aneurysm. However, there are no reported cases of rupture with massive hemorrhage. ◀

A copy of the references pertaining to this paper may be obtained by writing to The Journal, 3935 N. Meridian St., Indianapolis 46208.



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Carcinoma of the Penis

This new 13-page Professional Education Publication presents a compendious outline of the current management of penile tumors, emphasizing major controversies and discussing, in detail, the author's experience in the treatment of squamous carcinoma. Staging tables and surgical line drawings are included. Mail requests for copies to the Indiana Division, American Cancer Society.

Administering Immunotherapy

"Immunotherapy" (*RN* magazine reprint, April/May 1975) is an article available to nurses through request to the American Cancer Society. Immunotherapy is a relatively new treatment for cancer, based on a weapon as old as man, his immune system. Nurses in cancer centers have an unusually important role in administering and teaching cancer patients how to carry out their treatments at home. This article describes an advance in therapy that may in time control some kinds of cancer. Consequently, it should be of interest to all nurses.

Sense In The Sun

The Public Education pamphlet of the American Cancer Society on skin cancer, *SENSE IN THE SUN*, has been completely updated. The new pamphlet concentrates on the major cause of most skin cancer: overexposure to the sun. Groups at high risk for skin cancer are also pointed out as well as ways to moderate the harmful effects of the sun on the skin.

Cigarette Smoking Among Teen-Agers and Young Women

(Excerpts from a report published by the National Cancer Institute in cooperation with the American Cancer Society. Continued from the March issue.)

Changing Moral Norms

Bolstering the impressions of the all pervasive smoking environment and helping to explain in part the sharp increase in smoking among teen-age girls, are the changes in

the prevailing social norms. With teen-age boys, cigarette smoking continues to go hand-in-hand with social uneasiness, the need to be popular with the opposite sex, the urge to prove one's masculinity. It is an intrinsic part of adolescent boy rebelliousness. With teen-age girls, the picture which emerges is very different. The teen-age girls are socially considerably more at ease with their own peers, more "sophisticated" than their male peers, and less in need of social props. The rebelliousness against adult society is now very much a part of the girls' environment.

The New Values

These new values originally generated by college youth in the sixties and now permeating the majority of young people represent the breakdown of previous moral norms and are characterized by the rejection of authority, emphasis on the emotional rather than the rational, freer sexual morality, a strong accent on self and self-fulfillment, the acceptance of illegal drugs and a more informal life style. They make it easier to do what one wants to do and to resist arguments against it.

Opportunities for Change

Interestingly, opportunities for curbing smoking among young people are also tied in with these same new values. For the very emphasis on the importance of self, the need to be an independent thinker, the importance of physical well-being can provide more effective incentives against smoking than the more traditional threat of future health hazards.

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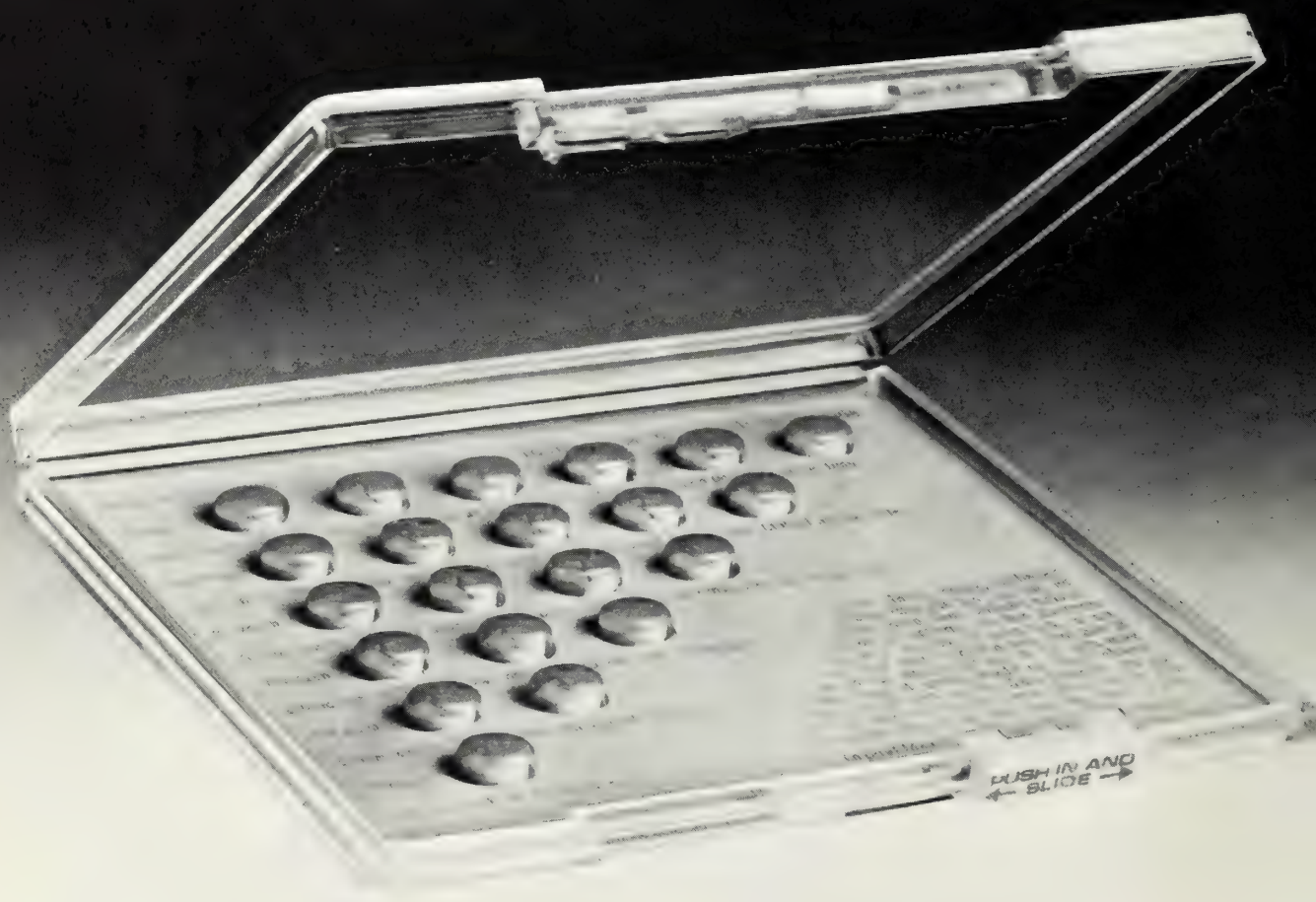
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Respiratory Problems in the Newborn

Part Two: Treatment of Respiratory Problems in the Newborn

RICHARD L. SCHREINER, M.D.
MARILYN B. ESCOBEDO, M.D.
EDWIN L. GRESHAM, M.D.

Indianapolis

IN Part One of Respiratory Problems in the Newborn (June 1976) an approach to the diagnosis of the more common neonatal problems which present with respiratory distress was discussed. During the past 10 years there has been a remarkable reduction in the mortality and morbidity associated with neonatal respiratory disorders. In our nursery during 1971 there was approximately an 80% mortality in newborn infants requiring artificial ventilation; now there is better than 80% survival. This remarkable improvement has resulted, in part, from meticulous observation of minute-to-minute changes in the child's condition and from careful attention to a multitude of respiratory and non-respiratory factors which can adversely affect outcome. Just as the causes of respiratory distress are varied, so are the methods for management. This discussion will deal with the treatment of respiratory disorders in the newborn and the management of the problems which accompany them.

Amelioration of the Primary Disorder

Once the cause of neonatal respiratory distress is determined cer-

tain therapeutic measures are clearly indicated: surgical intervention for tracheoesophageal fistula or diaphragmatic hernia, elimination of a tension pneumothorax by chest tube drainage, antibiotics for pneumonia, digitalis and diuretics for congestive heart failure and correction of complicating factors such as hypocalcemia, hypothermia and anemia.

A favorable outcome for neonatal diseases is often jeopardized because of failure to provide general but nonetheless essential adjunctive support. Following are some of the supportive measures which are applicable to almost all cases of neonatal respiratory dysfunction.

Oxygen

Oxygen warmed to 32-34C (89.6-93.2F) with a 60-80% relative humidity is administered to maintain the arterial pO₂ at 50-80 mm Hg. Micro methods for making periodic blood gas measurements are indispensable in the management of any newborn infant requiring supplemental oxygen. The method of oxygen administration must be individualized to maintain the required oxygen and yet permit reasonable access to the infant. For example, 40% oxygen can usually be maintained within an incubator equipped with portholes for patient care. When a concentration of more than 40% is necessary, it is preferable to use an oxygen hood within the incubator so that large fluctuations of ambient oxygen levels do not occur when the ports are opened. The newborn does not tol-

erate even brief hypoxic episodes, so strict precautions for stabilization of the oxygen environment are mandatory. Stresses imposed by taking the child out of oxygen for x-rays, weighing, etc., can result in such serious extra- and intra-pulmonary shunting that the previously stable infant may be placed in jeopardy of life.

Temperature

There are critical non-respiratory functions which require careful attention when managing newborn infants with respiratory distress (Table 1). One of these, sustaining body temperature, has been shown to increase the survival rate of low birth weight infants. A method commonly utilized incorporates the use of a servo-controlled heat source which will maintain the abdominal skin temperature at 36-36.5 C

TABLE 1
Factors Influencing Outcome of Respiratory Disorders

- Oxygenation
- Temperature
- Fluid balance
- Circulation
- Electrolytes
- Acid-base homeostasis
- Nutrition
- Bilirubin
- Glucose (urine and blood)
- Calcium
- Hematocrit
- Infection
- Patent Ductus Arteriosus

From the Department of Pediatrics, Indiana University School of Medicine, the James Whitcomb Riley Hospital for Children, Indianapolis 46202.
Correspondence to Richard L. Schreiner, M.D., Indiana University School of Medicine, Riley Hospital, 1100 W. Michigan St., Indianapolis 46202.
Supported in part by Ross Laboratories.

(96.8-97.7 F). This technic will generally keep the baby's axillary temperature in the desired range of 35.8-37.3 C (96.5-99.1 F) while providing a thermoneutral environment in which the child does not need to increase or decrease his oxygen consumption for purposes of thermoregulation.

Hypothermia has been shown to increase oxygen requirements as the skin temperature drops below 35.6 C (96 F) and may result in tachypnea, apnea, metabolic acidosis, hypoglycemia, disseminated intravascular coagulation and peripheral vasoconstriction. Secondary complications such as an increased risk of kernicterus and impaired surfactant production may also follow inadvertent hypothermic stresses. On the other hand, hyperthermia can be equally devastating since it increases metabolic demands and oxygen consumption and may cause episodes of apnea.

The prevention of hypothermia must start in the delivery room. When a premature baby is anticipated, the delivery room temperature should be increased to 70 F or greater and the overhead warmer and incubator should be warmed in advance. The baby should be dried immediately and very thoroughly with absorbent towels and all resuscitative measures should be done under the overhead warmer. When the infant is stabilized, he should be moved to the nursery in his warmed incubator rather than carried in arms. Preventing hypothermia can significantly improve a premature infant's prognosis and prevent a mild respiratory problem from becoming a severe one.

Fluid Balance and Circulation

Intravenous glucose and fluids are administered to all infants with significant respiratory difficulty to avoid aspiration from feeding, hypoglycemia and dehydration. A 10% glucose solution (D₁₀W) is infused at a rate of 80-100 ml/kg/day for the first 1-2 days, and thereafter D₁₀W with 20 mEq/liter of sodium chloride or sodium lactate and 20 mEq/liter of potassium chloride is

administered at a rate of approximately 100-125 ml/kg/day. Children under radiant warmers may require 120 ml/kg/day or more from the onset. Generally, the child who weighs near one kilogram should *not* be kept under a radiant heat device because of the difficulty of coping with enormous evaporative water losses and secondary hyperglycemia which results from high infusion rates.

Serum electrolytes are obtained daily and the infusates are modified to compensate for abnormalities when necessary. Urine output and/or specific gravity should be monitored routinely on all sick newborns. When the urine excretion falls below 2 ml/kg/hr or the specific gravity as estimated by a hand refractometer rises above 1.010, the rate of intravenous fluid administration is usually increased. The syndrome of inappropriate antidiuretic hormone secretion is not uncommon in the sick newborn (i.e., hyponatremia, natriuresis and concentrated urine) and must be ruled out before increasing fluid infusion rates.

Blood pressure should be monitored every one to four hours or more often, depending upon the severity of the child's illness. The blood pressure of an infant with an umbilical arterial catheter can be followed continuously by means of an in-line pressure transducer. In most cases the *mean* arterial pressure is obtained by this method. If this instrumentation is not available, a sterile water manometer (as used for measuring spinal fluid pressures) can be filled with isotonic saline and attached intermittently to the ar-

terial line. To convert the reading obtained to mm Hg, simply divide centimeters of water by 1.35.

At present, the most reliable non-invasive method for determining infant blood pressure is by means of Doppler technology which provides both systolic and diastolic measurements. Data on normal systolic pressures in small infants are limited; however, tentative guidelines for normal, mean, systolic and diastolic pressures are provided in Table 2. If the blood pressure falls below the lower value and/or the patient shows clinical signs of poor perfusion (decreased urine output, elevated specific gravity, metabolic acidosis, poor capillary filling) a careful investigation of possible cause is indicated. Potential contributing factors include sepsis, hypoxia, cardiac decompensation or blood loss—e.g., placenta previa, fetal-maternal transfusion, twin-to-twin transfusion or iatrogenic causes.

Decreased tissue perfusion due to hypotension frequently results in metabolic acidosis, hypoxia and disseminated intravascular coagulation. Serious damage to vital organs such as the kidney, intestine and brain may occur. Supportive treatment of symptomatic hypotension not caused by congestive heart failure includes the administration of plasma expanders (whole blood or 5% protein solutions) at a rate of 10-20 ml/kg over 30 minutes. One must be careful not to overload the vascular system since congestive heart failure may result.

Frequent cardiac auscultation and evaluation of the quality of peripheral pulses will permit the early diagnosis of a patent ductus

TABLE 2
Average Systolic, Diastolic and Mean Blood Pressures (mmHg) During the First 12 Hours of Life in Normal Newborn Infants—According to Weight

Birthweight	Systolic	Diastolic	Mean
1001-2000 gm	49-52	26-31	35-40
2000-3000 gm	57-64	32-38	41-45
over 3000 gm	65-70	39-43	50-54

(Adapted from Kitterman et al., *Pediatrics* 44:959, 1969)

arteriosus. Failure of the ductus to close is relatively common in infants with respiratory difficulties, especially those born prematurely. Most close spontaneously but early recognition is important to identify those patients who may require medical management or surgical ligation because of intractable heart failure.

Acidosis

The patient's acid-base status requires frequent scrutiny. An elevated $p\text{CO}_2$ with low pH characterizes a respiratory acidosis and is often due to a reduction in alveolar ventilation or a ventilation/perfusion inequality. In general, the $p\text{CO}_2$ should be maintained between 35-50 mm Hg. Whenever the $p\text{CO}_2$ rises above 50 mm Hg, one should be prepared for mechanical ventilatory support.

If the $p\text{CO}_2$ is not elevated and the pH and serum CO_2 content are low, a metabolic acidosis is present. Possible causes of metabolic acidosis are included in Table 3. Proper diagnosis and management of these predisposing factors are essential. A conservative approach to acidemia should be considered if the cause of the acidosis has been determined and corrected in a patient who is not severely ill. A common example of this would be the child with acute hypoxic stress and metabolic acidosis who, after resuscitation, appears to be in no significant distress. If there is no additional compromise, this infant will most likely correct his metabolic acidosis without a need for chemical buffering.

In the moderately or severely ill patient, where the etiology of the metabolic acidosis cannot be determined or the cause is treated without a correction of the low pH, then pharmacologic intervention may be appropriate. Buffers such as sodium bicarbonate and THAM [Tris (hydroxymethyl) amino-methane] are reserved for correction of uncompensated metabolic acidemia. Traditionally, sodium bicarbonate has been the drug most frequently used to correct metabolic acidosis and

TABLE 3

Causes of Metabolic Acidosis

Tissue hypoxia (hypotension, low $p\text{O}_2$, anemia, abnormal Hgb- O_2 affinity)
Hypothermia
Sepsis
Necrotic tissue (necrotizing enterocolitis)
Others (diarrhea, renal defects, inborn errors of metabolism, late metabolic acidosis related to feeding)

TABLE 4

Sodium Bicarbonate—Potential Complications

Hyperosmolality
Cellular dehydration
Intracranial hemorrhage
Tissue necrosis
Hypernatremia
Increased $p\text{CO}_2$ (blood and spinal fluid)
Hypocalcemia (?)

acidemia in the newborn. As with most pharmacologic agents, side effects are observed with this drug that must be recognized to avoid serious iatrogenic complications. A summary of the most commonly encountered adverse effects is shown in Table 4. One important consideration is the increased osmolality which results from the infusion of a hypertonic solution. Standard preparations of 0.88 to 1.0 mEq/ml have an osmolality of approximately 1500 mOsm/liter. It is recommended to dilute this with at least equal parts of sterile water which still results in a concentration of almost 800 mOsm/liter—nearly 3 times the normal osmolality of the patient's serum. When infused over less than 5 minutes, the fluid shifts caused by this osmolar load may increase intravascular volume and possibly cause intracranial hemorrhage. Tissue damage may occur if this concentrated solution extravasates or is administered via a small caliber artery. Rapid infusion into

the umbilical vein, especially if the tip of the catheter is in a hepatic tributary, may cause severe hepatic necrosis. Electrolyte disturbances such as hypernatremia, with its potentially adverse effects, can also result from the sodium portion of the bicarbonate.

The $p\text{CO}_2$ of a patient may increase if the sodium bicarbonate is given rapidly or if the patient has impaired pulmonary function. Since the $p\text{CO}_2$ level is inversely related to the pH, this elevation in the carbon dioxide tension will reduce the drug's effectiveness in normalizing the acidemia. Carbon dioxide crosses biologic membranes with relative ease; therefore, a rapid rise in the $p\text{CO}_2$ may result in cerebral spinal fluid acidosis. This lowering of spinal fluid pH is thought to cause central nervous system depression and may interfere even further with the patient's ability to eliminate the accumulating CO_2 . The disproportionately large rise in $p\text{CO}_2$ after giving bicarbonate is observed most often in babies whose $p\text{CO}_2$ is greater than 50 mm Hg prior to administration. Although a $p\text{CO}_2$ greater than 50 is not an absolute contraindication to the use of sodium bicarbonate, it does require closer acid-base surveillance to assure that an adverse effect has not occurred.

An alternative to sodium bicarbonate as a buffer is THAM, which not only binds hydrogen ions but also reduces blood CO_2 . It is excreted by the kidney rather than lungs, so it is less dependent upon pulmonary function for effectiveness. In the past, THAM was thought to be superior to sodium bicarbonate in several respects, but recent studies have refuted this concept by demonstrating that THAM is only half as effective as bicarbonate as a hydrogen ion acceptor. The most common potential complications observed with the administration of THAM include apnea, hypoglycemia and an increased oxygen affinity for hemoglobin. Because it is excreted by the kidney, it must be used with extreme caution in patients with seri-

ous renal disease.

In summary, suggestions for treating acidosis with acidemia in the newborn are: 1) For a predominantly respiratory acidosis do not use sodium bicarbonate or THAM—the treatment is ventilation; 2) Determine and correct the underlying cause of the metabolic acidosis; 3) In general, use diluted sodium bicarbonate solutions rather than THAM, and 4) Chemical correction of acidemia with either sodium bicarbonate or THAM should always be accomplished slowly—i.e., infusion rates over more than five minutes.

Nutrition

The importance of providing adequate nutrition for infants with respiratory distress is frequently overlooked. The technic, volume and rate of caloric administration must be individualized to fit the needs and limitations of each patient. A variety of methods, including intermittent gavage, continuous intragastric or transpyloric tube feeding and peripheral hyperalimentation is available. The potential risks of each approach are significant and must be weighed against the potential adverse effects of prolonged malnutrition.

Hypoglycemia is commonly observed in any stressed infant because of limited glycogen reserves, reduced caloric intake and often an associated increase in metabolic demands. Monitoring the blood sugar at frequent intervals during periods of stress is essential. In general, if the patient's blood sugar falls below 40 mg%, the amount of intravenous glucose is increased. Conversely, if the urine sugar is $\frac{1}{2}\%$ or more by clinitest* or Diastix* on two consecutive specimens, a reevaluation of the serum glucose, urine output and glucose administration rates is necessary to avoid osmotic diuresis.

Bilirubin

Hyperbilirubinemia is present in nearly all newborn babies with sig-

nificant respiratory difficulties. Factors which predispose to kernicterus at lower bilirubin levels include prematurity, hypoxia, acidosis, hypothermia, hypoglycemia and hypoproteinemia. Since many of these conditions may complicate the course of a child with respiratory distress, it is important to follow bilirubin and serum protein concentrations very closely. Exchange transfusions may be required at total bilirubin levels considerably lower than those recommended for healthy infants.

Miscellaneous

Because of the high incidence of low total calcium values in infants with respiratory distress, we frequently add calcium gluconate to the intravenous solutions. Two milliliters of 10% calcium gluconate added to each 100 ml of I.V. fluids will usually correct the serum calcium in the asymptomatic child within 24-48 hours. If there is clinical evidence of hypocalcemia—i.e., seizures, irritability, apnea, or cardiac arrhythmias, a more rapid correction is indicated. Two milliliters of 10% calcium gluconate per kilogram of body weight given by slow intravenous push with careful monitoring of heart rate will usually correct the acute manifestations. Any child with abnormalities of calcium homeostasis should have a serum calcium level determined at least daily.

Iatrogenic anemia can develop quite rapidly, especially in the low birth weight child who requires frequent blood sampling to monitor his progress. The hematocrit reading is not always a reliable index to the volume of blood removed from the newborn infant. If the baby who has had a significant fraction of blood withdrawn is suddenly stressed—e.g., sepsis, hypoxia, hypothermia, etc., there may be a precipitous fall in the hematocrit reading or effective blood volume.

It is important to keep precise records of the amount of blood removed. Whenever the amount taken out exceeds 10-15% of the child's blood volume, or the hematocrit

reading falls below 40%, a replacement transfusion is performed. The child whose cardiac status is stable will tolerate 10 cc per kilogram of packed cells or whole blood if given over 30 minutes. During the convalescent period blood is transfused more conservatively.

We do not place children with respiratory distress or those with umbilical catheters upon prophylactic antibiotics routinely. However, when there are factors in the history or clinical course that suggest infection, then cultures of blood, urine, spinal fluid and other appropriate sites are obtained and antibiotics are initiated.

Assisted Ventilation in the Newborn

Because assisted ventilation cannot be adequately discussed in a short article, only a few generalities concerning the handling of newborn infants with severe respiratory distress will be mentioned. The factor which is most important in determining the success of any ventilatory assistance program is the competence of the team caring for the patient. Although elaborate equipment is often useful, it is not nearly as crucial as the team of physicians, nurses, respiratory therapists and other support personnel. A physician experienced in assisted ventilation for the NEWBORN must be available 24 hours a day and preferably should be hospital-based. When a doctor cannot be in the hospital at all times, the non-physician personnel must be trained meticulously to treat unexpected emergencies on an *interim* basis until the doctor arrives.

Continuous positive airway pressure (CPAP) has dramatically improved the outlook for premature infants with hyaline membrane disease. Continuous distending pressure may be administered by a number of modes including head box, mask, endotracheal tube, nasal cannulae, negative pressure devices, and also can serve as an adjunct to ventilator-assisted respiration. No one mode of administration has been proven more effective than another in all instances. The main

*Ames Company, Division of Miles Laboratories, Inc., Elkhart, Indiana.

indications for CPAP at this point are disease states which respond to increased transpulmonary pressure—e.g., hyaline membrane disease, pulmonary edema and atelectasis. Severe apnea of prematurity may also be improved by the use of this technic. CPAP may have significant adverse effects, including decreased cardiac output due to impaired venous return, and an increased functional residual capacity. These are problems that are seen most often during the recovery phase when pulmonary compliance is improving.

It is important to remember that CPAP does not significantly improve minute ventilation. The child who is hypoventilating to the point of decompensation with an elevated $p\text{CO}_2$ and acidemia requires ventilator assistance and not CPAP alone.

Complications of CPAP include pneumothorax, pulmonary interstitial emphysema, pneumomediastinum and pneumopericardium.

When administered by head box there may be lacerations of the neck, elevated noise levels and, possibly, an increase in intracranial hemorrhages. Nasal prongs and endotracheal tubes can predispose to infection, cause nasal necrosis and become inadvertently occluded. Gastric distension can result from all methods of delivery and may require an intragastric tube for decompression.

Epilogue

The remarkable improvement in the outlook of preterm infants, especially those with respiratory distress, has occurred because of a number of developments in neonatal care.

Ventilators have been designed for these smallest sick patients. Their place in the management of respiratory problems is no longer that of a desperate measure used for a dying infant, but that of a judicious intervention in the course of a

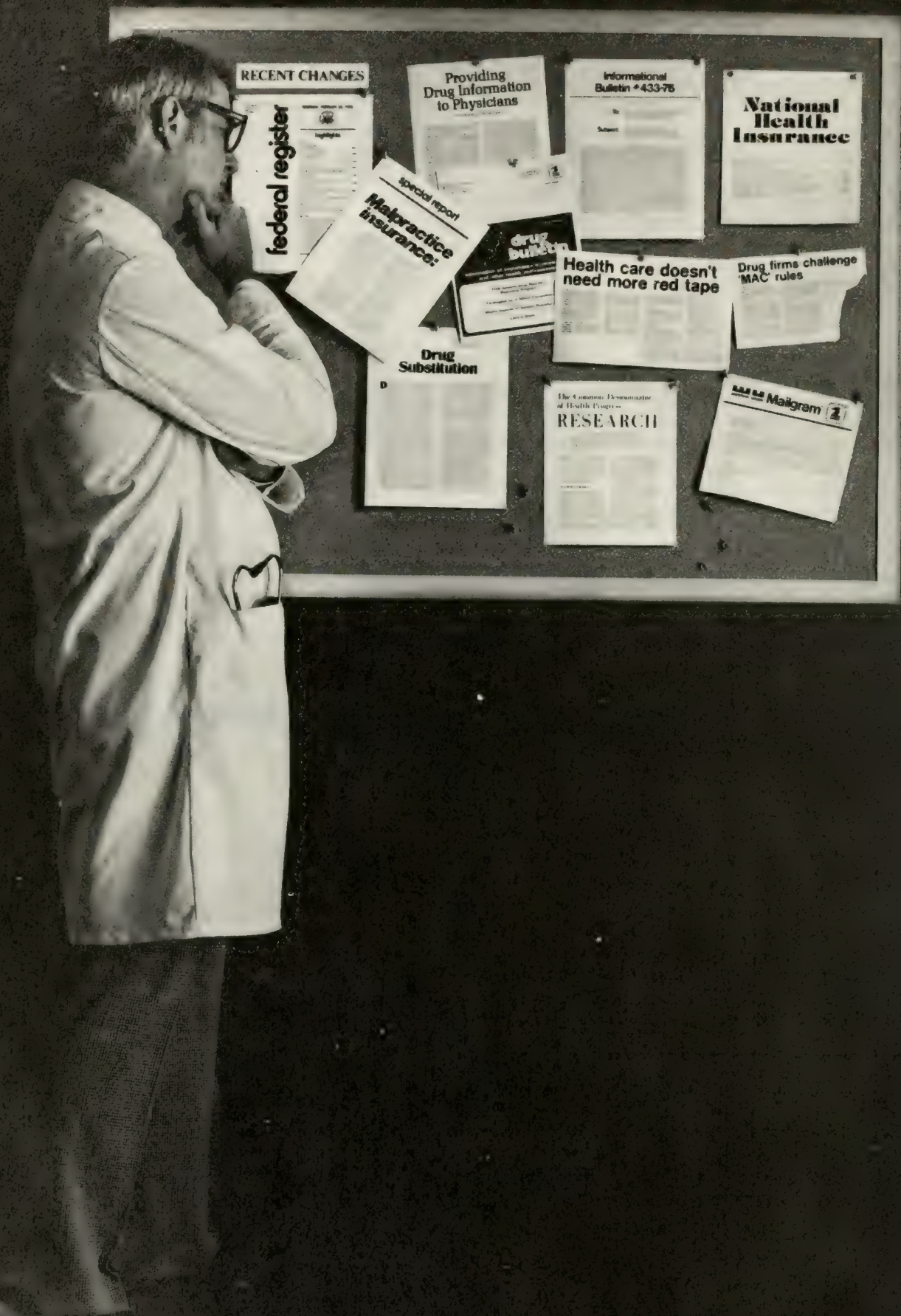
serious illness. The use of constant distending airway pressure has been a major advancement in the supportive management of hyaline membrane disease and has allowed many infants to recover without the necessity of intubation and the attendant risks of mechanical ventilation. Referral centers for newborns have been developed where the special skills and services necessary for seriously ill babies are available around the clock.

However, the most important contributions have been made in prevention, good early management, the recognition of the baby who is developing serious problems and the transport of that patient while he remains in stable condition.

With the continuing improvements in the total care of the baby during fetal life, intrapartum, the immediate postpartum period and the crucial first hours of life, the trend toward lower mortality and morbidity should be sustained. ◀

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Mailgram 2

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005



Diagnosing and Treating Delirium

DAVID F. WEHLAGE, M.D.
South Bend

Definition

DELIRIUM (acute brain syndrome) is an acute, temporary, organic alteration and dysfunction of the brain caused by a relative insufficiency of cerebral metabolism.¹ If the cause for the metabolic insufficiency can be removed, there is an excellent potentiality for recovery. If it is not removed, there may be deterioration to irreversible brain change or a chronic brain syndrome. This possibility of permanent damage added to the possibility of harm to the patient during his period of delirious confusion makes the rapid diagnosis and treatment of delirium a matter of great importance.²

Clinical Features

Delirious patients exist wherever there are sick people. Unfortunately, our ability to create delirium is increasing far more rapidly than our ability to recognize and deal with it. As more effectual ways of producing brain damage are developed and as more potent drugs and prolonged surgical procedures are administered to patients, delirium is certain to increase.

The prodromal symptoms of delirium include restlessness, poor attention, extreme emotional irritability and signs of illusions (misidentifying images or objects in the room). The early symptoms may be of rapid or gradual onset. A gradual sleep disturbance with vivid dreams or nightmares should alert one to delirium. In fact, *any nighttime agitation is delirium until proven otherwise*. The night nurse will likely be the one to observe the

impending delirium, even though the patient may appear lucid on morning rounds. *Variability in the clinical state is the hallmark of delirium*. At the onset of delirium the patient begins to show a disorder of "grasp," which indicates an inability to comprehend the relationships to the elements of one's surroundings. For example, the patient mistakes unfamiliar places and persons for familiar ones, such as regarding the hospital as his home.

As frank delirium emerges, the patient becomes agitated and frightened with paranoid delusions. He is initially disoriented to time and probably will show some confusion about where he is. Visual hallucinations are prevalent; auditory hallucinations may be present but are not usually characteristic of an organic brain state. The patient's attention span is so short that severe memory deficits for recent events become obvious. It should be emphasized that any confusion about time and any loss of memory represents an organic brain state, not a functional emotional state. Accidents occur when the patient's decreased attention span, disorientation and frightened agitation force him to inappropriate behavior. Further deterioration leads to apathy, with the patient possibly picking "things" off his bedclothes or out of the air.

Etiology

The primary factor in delirium is an organic insult that affects the functioning of the brain. The insult may be circulatory, infectious, metabolic, hormonal, traumatic or toxic. The physician needs to look for all the possible reasons for the insufficiency of cerebral metabolism, many of which may be of a

systemic nature like pneumonia, electrolyte imbalance, anemia, vitamin deficiency, cardiovascular problems, hyperthyroidism and hepatic failure. Intoxication from medication is an extremely frequent etiology.

Delirium uniquely demonstrates the interplay between an organically noxious stimulus and the immunity of the person to withstand the attack, the major considerations of which are the personality coping mechanisms. Delirium can be activated and aggravated by environmental and emotional aspects of the climate surrounding the patient. Because the environment that significantly affects delirium can also precipitate a functional psychosis, it behooves the physician to understand the socio-emotional, environmental aspects of his patient as well as the organic aspects.

The hospital environment can be considered as a multiplicity of stimuli that impinge on and must be handled or screened by the patient. There is a psychobiological drive for stimulation which includes the need for a certain *quantity* or amount of stimulation along with the qualitative aspects of the *variety* and the *meaningfulness* of the stimuli. An environment without some variation of stimuli or without stimuli that are meaningful and familiar to the patient may be harmful.

To properly evaluate the quantity and quality of environmental stimulation, nine categories of stimulus variables need to be considered.³ The following chart explains the nature of sensory overload or deprivation that contributes significantly to the morbidity in a hospital setting:

Dr. Wehlage is associate professor of psychiatry at the Indiana University Medical School, South Bend.

	SENSORY OVERLOAD	NORMAL	SENSORY DEPRIVATION
1. Sensory input variables:			
a. visual	Lights on constantly; flashing lights; monitors	Variety, e.g., diurnal variation	Dark room, fog tent, eye-patch, medication blur
b. auditory	Hissing, chatter, motors vibrating	Radio, conversation	Mumbling, silence
c. tactile	Excessive pain; rough, excessive handling		No touching, numbness, overmedicated
d. taste	Forced feeding	Can feed self	Intravenous feeding
2. Movement variables	Total restraint	Sit up, walk	No restraint, but too tired or weak to move
3. Milieu variables:			
a. people milieu	Too many (no privacy), smothering, overemotional	One nurse, compassionate family	Absent or cold people
b. non-people milieu	Inconsistency; shifting from room to room	Familiar objects; predictable routine	Unfamiliar, boring
4. Communication variables:			
a. verbal		Can talk	Tent, respiration problem, tracheostomy
b. signals		Can write, use hand signals, etc.	
c. affect		Can cry, laugh, etc.	Suppresses feelings, can show no feeling
5. Activity variables	Too much to do—diagnostic studies, etc.; no sleep	OT, hobbies, diagnostic studies evenly spaced	Nothing to do; no meaningful acts
6. Time/Control variables:			
a. progress	Expectations beyond patient's capabilities, e.g., feeding self	Aware of progress of clinical state	Unsure of or no progress
b. control		Activity, ambulation	Control not given over bedside table, bed rests, etc.; catheter, Strycher frame
c. time		Knows time progression, clocks available	Slow, endless, no clocks or calendars
7. Cultural variables	Voodoo, magic, religion		No religion, no philosophy, language not understood
8. Circumstantial variables:	Emergency, unpredictable procedures	Planned, predictable procedures	
9. Personality variables—	Denial of procedure Past mental illness Social problems Gastrointestinal functional complaints		

The goal is to normalize the environment for the patient as well as normalize his medical state. It is ideal to have a patient be able to move around some, do most things for himself, have familiar, meaningful objects from home around him on a bedside table he can reach, be able to communicate with a nurse he knows daily in a room that has some privacy and a window where night and day are obvious. He needs

contact with some meaningful entertainment to pass time and should be able to understand his illness enough to trust his physician's reports of improvement. All diagnostic procedures should be clear, and pain should be relieved as much as possible to insure proper amounts of sleep. One little known fact to consider is that *visual hallucinations are increased when the patient is confined to lying on his back, and*

the hallucinations will be relieved just by allowing him to sit up.

The personality variables in item 9 in the chart predispose one to delirium or a functional psychosis. It is extremely important to also know which people are most predisposed to suffer from a delirium.⁴ The high risk group includes: (1) the aged, (2) a frightened person with morbid expectations about what will happen to him, (3) a

person receiving large quantities of medication of any type, (4) the alcoholic, and (5) the depressed, hopeless person.

Treatment

The first concern in treatment involves protecting the patient from harming himself by providing continuous good nursing care and observation. Family members may be of help if intensive observation is needed, especially since their familiar presence may calm the patient. Delirious patients are not generally suicidal but are erratic in their behavior. The attitude needed to manage the delirious patient is one of *kind firmness*. He should be physically, firmly contained and verbally reassured that what he is experiencing is not unusual and will improve if he can cooperate. Being repetitive about reassurance and repetitive in telling the patient where he is and what is being done to him will have a calming effect on the patient. Attending to the environmental stimuli specified is mandatory.

The second simultaneous concern in treatment is the supportive and investigative medical care. A search for the medical reason for the altered brain function needs to be pursued. It is especially important to review the drug regimen and withdraw any unnecessary medications. If any suspicion of alcoholic

withdrawal is present, active intervention is essential.

The third aspect is the drug therapy needed to specifically manage the delirium or functional psychosis. A neuroleptic with some sedative properties (Thorazine, Mellaril, Haldol) is the drug of choice, except in delirium tremens, where Librium remains appropriate. The neuroleptic not only quiets the patient but also improves his thinking and helps clear his confusion in a way the minor tranquilizers will not. A typical order for a middle-aged patient reads: "Thorazine Concentrate (or Mellaril Concentrate), 75 mg every four hours when patient is awake." The medication needs to be titrated as to amount so that the patient is comfortable but arousable. It is not necessary to awaken the patient, although around-the-clock medication is mandatory, since the medication can be given again when he awakens. The second essential medication is a hypnotic, since lack of sleep is one of the more potent precipitants of delirium. Delirium also tends to be worse at night, and sleep can ease it. The only hypnotics to consider are Dalmane, 30 mg at bedtime, or chloral hydrate, 1,000 mg at bedtime. Barbiturates are contraindicated since they complicate the clinical picture with paradoxical agitation. It is possible

occasionally to use chloral hydrate around the clock as the principal medication—e.g., chloral hydrate, 500 mg three times a day and 1,000 mg at bedtime, without using any neuroleptic. *Drug treatment in delirium should never be used only "prn."* It needs to be given regularly as ordered for the duration of the delirious process and then withdrawn slowly over several days to insure that no relapse occurs.

Conclusion

Delirium can destroy a planned medical regimen very easily, but it can be rapidly diagnosed and treated effectively. This discussion emphasizes the ample opportunity of prophylactic intervention possible in delirium.

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Ethylene Glycol Poisoning

KEVIN J. LAVELLE, M.D.
Indianapolis

ETHYLENE glycol poisoning continues to be a nettlesome problem from both a clinical and biochemical point of view. Forty to sixty deaths following ethylene glycol ingestion are reported annually, though the number and clinical spectrum of the intoxications are much larger.¹ Ethylene glycol is used most commonly as an automotive antifreeze preparation and ingestion may be accidental or it may be used as a deliberate substitute for alcohol. Prompt and vigorous therapy can provide salutary results in potentially fatal ingestions.

Case Summary

A 48-year-old man was admitted to Wishard Memorial Hospital on the morning of 11/4/76. He was disoriented, agitated and unable to provide any history. The blood pressure was 120/78 mm Hg, the pulse 130/min and respirations 30/min and Kussmaul in nature. The ocular, cardiorespiratory and abdominal examinations disclosed no abnormalities except moderate hepatomegaly. The neurologic evaluation was non-revealing except for the disorientation.

Result of the hemogram was normal. The serum sodium concentra-

tion was 138 mEq/liter; potassium 5.2 mEq/liter; chloride 95 mEq/liter and the bicarbonate 3 mEq/liter. The arterial blood PO₂ was 133 mm Hg, the PCO₂ 13 mm Hg and the pH 7.09. The blood urea nitrogen (BUN) was 19 mg/dl, the serum creatinine 1.8 mg/dl, and the blood sugar 180 mg/dl. The calculated serum osmolality $[2(\text{Na} + \text{K}) + \frac{\text{blood sugar}}{18} + \frac{\text{BUN}}{2.8}]$ was 303

while the measured osmolality was 328, indicating the presence of unmeasured anion. Results of the chest x-ray and EKG were normal. Serum determination of acetone, salicylates, methanol, ethanol and isopropyl alcohol were all negative. The serum lactate was 0.5 mEq/liter (N 0-2 mEq/liter). Microscopic urinalysis demonstrated hematuria and calcium oxalate crystals. The ethylene glycol level obtained three hours after admission was 48 mg/dl.

Treatment was initiated on admission with intravenous saline, sodium bicarbonate, thiamine and pyridoxine. After the ethylene glycol was identified, ethyl alcohol was added to the intravenous fluid; later that afternoon the patient was hemodialyzed for four hours. The ethylene glycol level had declined to 24 mg/dl at the beginning of dialysis and was reduced to 3 mg/dl at the conclusion. The next morning the serum electrolytes were normal; however, the serum

creatinine had risen to 2.6 mg/dl. The remainder of the patient's hospitalization was characterized by a gradual rise in the serum creatinine to 5.3 mg/dl and the BUN to 50 mg/dl for the first week and thereafter a decline to 2.7 mg/dl, and 48 mg/dl for the serum creatinine and BUN, respectively, at the time of discharge one week later.

Discussion

Ethylene glycol is a colorless, odorless, water-soluble liquid reported to have a bittersweet taste. It is a member of the straight-chained saturated polyalcohols, and since it has the property of depressing the freezing point of water, it is the major ingredient in automotive antifreeze preparations. The toxicity of this glycol was unrecognized in the early decades of this century; the safety of the compound was attested to by an intrepid individual who consumed 30 ml and fortunately suffered no ill effects.² This glycol was then considered safe for use as a solvent for medicinals. It wasn't until the 1930s that reports surfaced incriminating ethylene glycol as a cause of renal failure and death.³

Metabolism

Familiarity with the metabolism of ethylene glycol is central to the organization of a therapeutic program. The toxic manifestations of this compound are quantitatively the result of the metabolites rather

From the Department of Medicine, Indiana University School of Medicine, and the Renal Section, Wishard Memorial Hospital, Indianapolis 46202.

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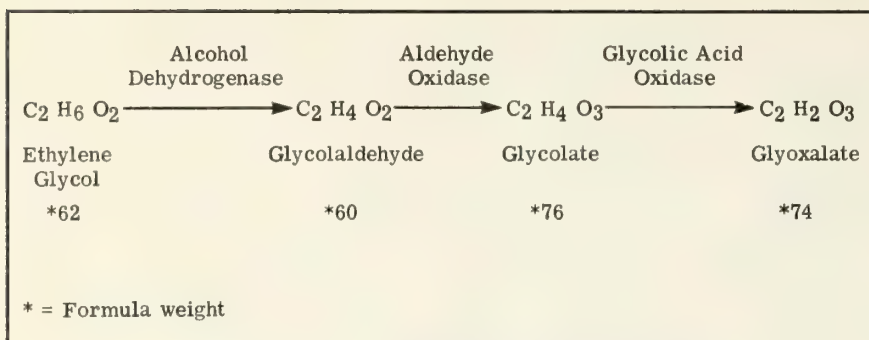


FIGURE 1
Oxidative metabolism of ethylene glycol to glyoxalate.

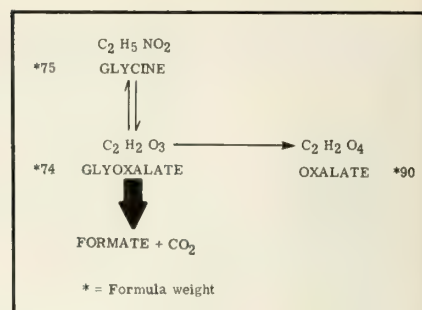


FIGURE 2
Glyoxalate converted chiefly to respiratory CO_2 . Conversion to glycine inhibited in presence of cofactor deficiency favoring increased conversion to oxalate.

than the parent compound. Ethylene glycol is oxidized in the liver by alcohol dehydrogenase to glycoaldehyde.⁴ This, in turn, is oxidized to glycolate and subsequently to glyoxalate.⁵ (Figure 1) The metabolism of glyoxalate may proceed via multiple pathways, the majority converted to oxalic acid, glycine or formic acid and CO_2 . (Figure 2) Quantitatively, the greatest fraction, approximately 60%, is converted to CO_2 . Cofactors such as pyridoxal phosphate and thiamine pyrophosphate are essential for the conversion of glyoxalate to non-toxic compounds such as glycine. Pyridoxine-deficient animals have marked increases in oxalate excretion.⁶ Ethylene glycol, per se, seems to have little toxicity. The half-life in the serum is approximately 3-4 hours. The lethal dose for man is estimated to be 100 gms, 1.4-1.6 gm/kg body weight. This would be equivalent to 100 ml of 100% ethylene glycol or 105-110 ml of most commercial antifreeze preparations. Animal studies of the relative toxicities of the metabolites indicate oxalic acid is the most lethal, a 60 mg/kg dose producing death, followed by glyoxalate 0.5 mg/kg, glycolate 1 gm/kg, and finally glycoaldehyde at 4 gm/kg.⁵ Oxalate does not undergo further degradation and its elimination from the body depends entirely on renal excretion. Experimentally, maneuvers to decrease the conversion of ethylene glycol to its metabolites have reduced the toxicity of the parent compound.⁷

Clinical Features

The manifestations of the toxic syndrome usually pass through three stages where abnormalities in specific organ systems predominate.^{8,9} The initial phase is dominated by alteration of central nervous system function. Within one to two hours after ingestion the patient may appear intoxicated, and this may proceed to coma, seizures and death within 12 hours, depending on the amount ingested. A normochloremic metabolic acidosis, with an increased anion gap indicating unmeasured anions, is the rule during the initial stages. Hypocalcemia may be seen and may represent chelation with oxalate and deposition in the tissues. Urine analysis will reveal the presence of calcium oxalate crystals in the urine four to six hours after the ingestion and may provide the only clue to the correct diagnosis in the comatose patient. Microscopic hematuria is characteristic, and there may be proteinuria and glucosuria. Examination of the cerebrospinal fluid at this point may indicate an acute inflammatory process with pleocytosis and increase in protein content. Autopsy studies of individuals who succumbed within a short time after ingestion (corroborated by animal toxicity studies) indicate the brain is edematous and covered with diffuse petechiae. Microscopically, a diffuse vasculitis involving the brain and meninges is evident. Calcium oxalate crystals may be seen in the vessel walls and perivascular cerebral tissue. The vascular changes are not dependent on

the presence of oxalate crystals, because the same changes are evident in the absence of oxalate crystals.

If the patient survives the first 12-24 hours, cardiopulmonary symptoms may become more prominent. Congestive heart failure, pulmonary edema and/or pneumonia may evolve. Petechial hemorrhages in the pleura, lungs and heart, with degeneration of myocardial cells, have been noted in fatal cases.

Survival beyond the first 48 hours may permit renal failure to supervene. Alteration of renal function may vary from anuric failure to mild or moderate elevation of serum creatinine and BUN, as was the case with our patient. The hallmark of the pathologic changes is renal tubular degeneration and necrosis. Calcium oxalate crystals may be widespread in the tubules and peritubular area. The toxic changes are not dependent on the presence of oxalate crystals and occur without obvious crystal deposition. Renal function may improve in spite of the continued presence of the oxalate crystals, which may persist up to two months following the initial insult. Oxalate deposition may occur in any organ and appears to be chiefly a perivascular phenomenon.

Diagnosis

Rapid diagnosis is imperative in ethylene glycol poisoning, because the half-life of the compound is brief—i.e., the longer the interval following ingestion, the greater the

fraction converted to the more toxic metabolites. The diagnosis should be strongly suspected in the patient who presents intoxicated or comatose with a metabolic acidosis. The more common forms of normochloremic acidosis can be rapidly eliminated by the appropriate serum determination—i.e., diabetic ketoacidosis (serum acetone and blood sugar), uremia (BUN and serum creatinine), salicylate intoxication and, finally, lactic acidosis. The absence of these entities in the patient with neurologic dysfunction, metabolic acidosis (normochloremic) and calcium oxalate crystaluria (Figure 3) is sufficient to begin therapy with the presumptive diagnosis of ethylene glycol poisoning. Laboratory facilities to do the appropriate testing may not be readily available for immediate diagnostic confirmation. Initiation of appropriate therapy should begin promptly and the toxicology determinations completed when feasible.

Therapy

Lacking a specific antidote, therapy is directed towards rapid elimination of unchanged ethylene glycol from the subject and reversal of the observed metabolic derangements. The observation that human liver alcohol dehydrogenase oxidizes ethylene glycol and that this oxidation is inhibited by ethanol prompted the use of ethanol in the treatment of experimental ethylene glycol poisoning.¹⁰ Ethanol alone doubled the median lethal dose of ethylene glycol in animal studies and increased the amount of unmetabolized compound recovered in the urine from 2-10 times the amount recovered without the use of ethanol. This indicated the lethal effects of ethylene glycol could be sharply reduced by ethanol and this information was first employed in humans in 1965 with gratifying results.¹¹ When the diagnosis of ethylene glycol poisoning is suspected or established, intravenous ethanol should be administered promptly. A loading dose of 2 gm (20 ml 10% ethanol in 5% dextrose and water)

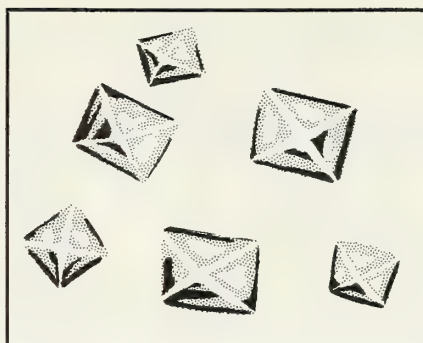


FIGURE 3
Calcium oxalate crystals presented diagrammatically as seen on microscopic urine analysis.

is given and followed immediately by constant infusion of 7-10 gms per hour to maintain a blood level between 1-2 mg/dl (infused at 1.0 ml/kg/hr).

The metabolic acidosis characteristic of ethylene glycol poisoning, in part due to the metabolites, needs to be vigorously corrected to reverse the immediate deleterious effect of acidosis on organ function and to minimize the amplification of metabolite toxicities on long-term organ survival. In 1966 Lyon noted a marked increase in calcium oxalate deposition in the kidneys of rats given ethylene glycol and ammonium chloride to acidify the urine, compared to animals given ethylene glycol alone.¹² Subsequently, Borden in 1968 evaluated the effect of alkali on survival and renal oxalate deposition in rats.¹³ Survival was increased fivefold by either sodium bicarbonate or ethanol individually, and sixfold by their combined use. Bicarbonate alone reduced renal oxalate deposition by 75% compared to controls and, when combined with ethanol, eliminated renal oxalate deposition entirely. In the clinical setting, the rapid reduction in the serum bicarbonate concentration represents utilization in buffering hydrogen ion released via the oxidation of ethylene glycol. The rapid onset of the acidosis and consumption of bicarbonate ion probably reflects a greater deficit in extracellular than intracellular bicarbonate ion. The extracellular bicarbonate concentration ($N = 23-26$ mEq/liter) is in

a volume approximately half that of the intracellular pool (10-12 mEq/liter). Reparation of the bicarbonate deficit can be largely based on the extracellular deficit if one keeps in mind both pools are in reality reduced (extracellular > intracellular). The deficit can be calculated by determining the extracellular volume using the following calculations:

Total body water =

$$\left[\begin{array}{l} 60\% \text{ male} \\ 50\% \text{ female} \end{array} \right] \text{body weight in kg.}$$

The extracellular compartment is one third the total body water, so that $0.2 \times \text{the weight in kg} = \text{extracellular water (liters)}$. Given the normal serum bicarbonate concentration minus the measured value $\times 0.2$ body weight kg (liters) = the bicarbonate deficit. Example $25 \text{ mEq/liter} - 3 \text{ mEq/liter} = 22 \text{ mEq/liter} \times (0.2 \times 70 \text{ kg}) = 308 \text{ mEq bicarbonate}$. The deficit should be corrected over the next four to six hours and the serum bicarbonate levels kept at generously normal levels, i.e., 25-28 mEq/liter. Urine pH should be monitored frequently and the bicarbonate infusion adjusted to keep the urine pH > 7.0.

In concert with the ethanol and alkali, efforts to maximize renal excretion of unchanged ethylene glycol are required. With a sustained diuresis as much as 5-8 gm of ethylene glycol can be recovered in the urine per 24 hours. Before initiating a diuresis, the volume status of the patient must be carefully assessed, since vomiting is common after ethylene glycol ingestion and may lead to dehydration. Fluid resuscitation may be required prior to initiating the diuresis and the state of hydration continuously monitored by the blood pressure, pulse, and/or central venous pressure. Urine flow of 400-500 ml/hour is optimum and will require careful attention to fluid and electrolyte balance. With effective inhibition of ethylene glycol conversion in the

liver, serum levels may decline slowly allowing increased renal excretion. Ethanol infusion and diuresis should be continued until the urine glycol levels are insignificant—i.e., up to 4-6 days post ingestion.

Vigorous supportive therapy as outlined will suffice in the majority of cases but in those situations where the ingested dose of ethylene glycol is 1.4-1.6 gm/kg or greater and serum levels are extremely high, i.e., 100 mg/100 ml, augmented elimination from the subject may be advisable. The use of dialysis—particularly hemodialysis—has proven very effective. The clearance of ethylene glycol by hemodialysis approaches that of urea clearance permitting a rapid reduction of serum ethylene glycol concentrations.¹⁴ Adjunctive therapy includes large doses of pyridoxine and thiamine to ensure adequate stores of cofactors necessary to permit conversion of glyoxalate to nontoxic glycine, rather than the very toxic oxalate. Treatment instituted early in the course of ethylene glycol poisoning may avert mortality and reduce the complications of organ system failure in those who survive. Unfortunately, some patients may still suffer a period of renal failure after recovery from the acute episode. These patients can reasonably expect to recover sufficient renal function to survive and should be afforded supportive dialytic therapy until recovered of sufficient renal function to sustain life.

Question: Given a patient with biochemical findings of severe metabolic acidosis, are there immediate diagnostic steps to take before giving alcohol and bicarbonate? In other words, what is the early dif-

ferential diagnosis and how does one proceed rapidly?

Dr. Lavelle: A useful approach to the patient with metabolic acidosis is to characterize the acidosis in terms of a high anion gap (normochloremic) and a normal anion gap (hyperchloremic). The normal anion gap is 12.4 ± 2.0 mEq/liter. The patients with normochloremic acidosis are usually uremic, in ketoacidosis or lactic acidosis, or intoxicated with salicylates, methanol, ethylene glycol or paraldehyde. The patients with hyperchloremic acidosis (normal anion gap) are commonly noted to have severe diarrhea, enteric fistula or ureteroenterostomies. Drugs which inhibit carbonic anhydrase, such as acetazolamide, and renal tubular acidosis also produce a hyperchloremic acidosis. Ethylene glycol produces a normochloremic acidosis. The diagnosis can be rapidly deduced by appropriate testing of renal function and determination of serum ketones, lactate and salicylate levels.

Question: Given the situation where the most common causes of normochloremic metabolic acidosis have been eliminated, one is then left with the likelihood of ethylene glycol or methanol intoxication. Is there any reason to delay therapy awaiting definitive toxicology studies?

Dr. Lavelle: The treatment for both forms of poisoning is essentially the same—i.e., volume resuscitation, rapid correction of the acidosis, inhibition of the conversion of the parent compound to the more toxic metabolites using ethanol and removal of as much unchanged compound from the body as rapidly as possible. If poisoning

with either compound is suspected, therapy should begin promptly.

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About Our Cover

Sunday, May 29, is the date for the 1977 world famous "Indy 500." Our cover photo was taken as the 33 cars came down the straightaway in front of the grandstands, pit area and control tower during the first lap of last year's race. With a million dollars in prize money at stake, the best drivers and cars are at the top of their form for Tony Hulman's "Gentlemen, start your engines."

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*Copies of this study and PUREPAC's annual report are available upon request.

TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

As I stated in last month's article (April), the prior gift tax law allowed a gift tax marital deduction in an amount equal to 50% of the fair market value of most types of property which a donor transferred to the donor's spouse. However, this marital deduction was limited to the amount of the gross gift so made to the donor's spouse. Thus, in the case where the donor gave a gift of under \$6,000 to the donor's spouse, the limitation became applicable. For example, if the donor gave \$5,000 to the donor's spouse, then the gift tax marital deduction was \$2,500, but this deduction was further limited to \$2,000 (namely, to total gifts of \$5,000 less the exclusion of \$3,000 for gifts of present interests).

Now, as stated in the April article, the gift tax marital deduction has been changed as follows. First, each individual (each spouse) is entitled to a gift tax marital deduction of a base amount of \$100,000. In addition, each individual may deduct one half of the total gifts to his or her spouse which gifts are *in excess* of \$200,000. However, even though the new law allows every individual a significantly greater gift tax marital de-

duction, the new computation of the marital deduction is considerably more complex than the former computation. And, unfortunately, Congress did not take the time to simplify this increased deduction—as much as Congress could have.

With this preface, I shall provide some examples to illustrate the new computation.

Example One

Assume that during January of 1977, H gives \$5,000 to H's spouse, W. Under the new law, the gift tax marital deduction would be \$2,000. Thus, H would have no taxable gifts for 1977

Total gifts	\$5,000
Exclusion	3,000
Gross gifts	2,000
Marital deduction	2,000
Taxable gifts	\$ -0-

Note—H began the year of 1977 with the \$100,000 base amount of the marital deduction, even though H may have given W significant gifts in the past. That is, each of us commenced 1977 with the full amount of the new marital deduction available to us—regardless of what gifts we have made prior to 1977.

At this point the question might also be raised as to how much of H's base amount of \$100,000 is remaining after H's gift in 1977. In my opinion, H has \$98,000 of the \$100,000 remaining, because the new law reduces the \$100,000 base amount only by the aggregate of marital deductions which have been previously *allowed* to H—that is, by the amount of the post-1976

gift tax marital deductions which have actually been taken by the donor, in this case, \$2,000. Thus, under my view, if an individual erroneously takes too large a gift tax marital deduction in a prior year and the prior year is already closed, then the donor must reduce the \$100,000 base by the total excessive deduction. On the other hand, if a donor neglected to take a marital deduction in a prior year and the prior year is already closed, then the \$100,000 base should not have to be *decreased* by the amount of the marital deduction which the donor *could have taken*.

Now, assume that during June of 1977 H makes another gift to W, this time in the amount of \$4,000. Because H had already utilized H's 1977 annual exclusion of \$3,000 for gifts of present interests to H's spouse, H will not be entitled to any further exclusion for 1977. However, as I have stated, H still has \$98,000 of H's \$100,000 marital deduction base remaining. Thus, H's marital deduction for this gift, for this quarter, is \$4,000. Therefore, H still has no taxable gifts for this quarter.

Total gifts	\$4,000
Exclusion	-0-
Gross gifts	4,000
Marital deduction	4,000
Taxable gifts	\$ -0-

After the second gift during 1977, H has, in my opinion, \$94,000 of H's \$100,000 marital deduction base remaining.

I shall continue these gift tax computations in next month's article. ◀

THE 1977 ROSTER OF MEMBERS

For convenience in handling and reasons of economy, this year's Roster will be published as a Supplement to the June issue and will be printed from information carried on our computerized Master File.

Additional copies of the Roster may be ordered at a cost of \$5.00. Copies of the June Yearbook are available at \$3.00. Please send check with order.

$\frac{20}{150}$

H

$\frac{20}{100}$

E A R

$\frac{20}{70}$

I N G I S

A S P R E C I O U S

A S S I G H T H A V E

Y O U H A D Y O U R H E A R I N G

T E S T E D L A T E L Y A S I M P L Y

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Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Aerobacter*, *Staphylococcus aureus*, *Proteus mirabilis*, and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: Blood dyscrasias (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura,

FOR THE PATHOGENS

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*nonobstructed, due to susceptible organisms

hypoprothrombinemia and methemoglobinemia); allergic reactions (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); G.I. reactions (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); CNS reactions (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); miscellaneous reactions (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. **Usual adult dosage:** 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with

cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy. Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spiro-lactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ . Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium[®] (triamterene, SK&F Co.), and

leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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The Auxiliary Reports to ISMA



This is the beginning of an exciting year for the Indiana State Medical Association Auxiliary as it moves toward its 50th anniversary on Sept. 28, 1977. We hope the Indiana State Medical Association will join in our anniversary celebration at the ISMA annual meeting in Indianapolis in October.

As another president said not long ago, "I have surrounded myself with good people" to help guide the Auxiliary through its 50th year. Communications will be a two-way street and success will depend on all of us. The Auxiliary is ready and willing to assist the ISMA in any way possible and we, in turn, could hope for your assistance when needed.

The auxiliary is in the process of establishing priorities for this year; such plans include immigration, VD education, TV violence, blood donation, AMERF and membership. We have the privilege, through our organization, to help our mates as they work for better health care and health education. Let us be aware of the needs waiting to be met by our special talents and energies. All ISMA members are asked to encourage their spouses to join the Auxiliary. Many other organizations will try to recruit them for volunteer work—but we can share ourselves, our compassion, our experiences and our time in the **medical auxiliary**.

A handwritten signature in cursive script that reads "Mary K. Stanley".

Mary K. (Mrs. John R.) Stanley
President, ISMA Auxiliary

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 46208

Please send me an application form for a scientific exhibit at the ISMA Annual Convention, Oct. 23-26, 1977, at Indianapolis

I propose to exhibit _____

Name _____

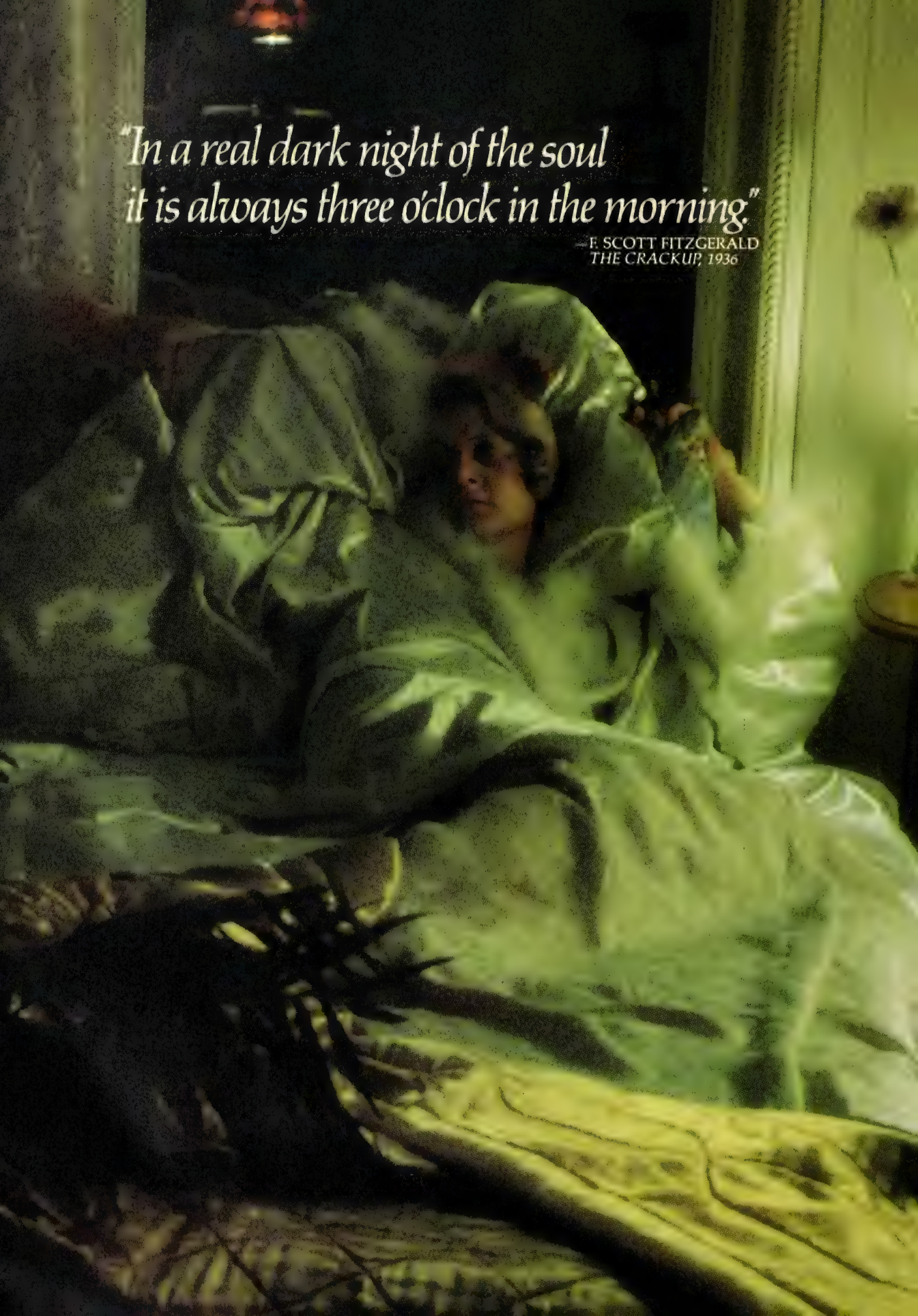
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Because of limited space the committee has set a limitation on scientific exhibits. Consequently, the committee will allocate space on a priority based on date of receipt of the application.

*"In a real dark night of the soul
it is always three o'clock in the morning."*

—F. SCOTT FITZGERALD
THE CRACKUP, 1936



Insomnia

a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin[®] (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.¹ Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information

ADAPIN[®] (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

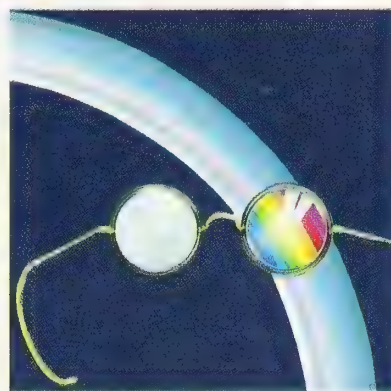
Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response.

Usual optimum daily dosage is 75 mg to 150 mg per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



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THE INDIANA STATE MEDICAL ASSOCIATION

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1977 Annual Meeting — Oct. 23-26 — Hyatt Regency Hotel, Indianapolis

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of the INDIANA STATE MEDICAL ASSOCIATION

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Let Us Be Realistic

QUOTE: "Our aspirations clearly exceed our resources . . . that we still cling to the idea that poverty can be eliminated, ignorance overcome, discrimination eradicated and hunger assuaged."

Dr. Theodore Cooper, former assistant secretary of health, spoke before the American Society of Law and Medicine last year on the general subject of medical malpractice liability and related problems. The above quotations from his speech reflect the underlying theme of his presentation.

Dr. Cooper, in introducing his dissertation, said he wanted to present some new points of view in addition to the conventional aspects of the malpractice mess with which everyone is now familiar. He said he thought we ought to take a longer view of the societal factors.

He sounded like Mr. Ruckelshaus

who, a couple of years ago, when he was in Washington, said the trouble with the world was that it wanted everything to be perfect. And, since perfection is impossible, the world is bound to be disappointed all the time.

Dr. Cooper says: "We are involved . . . with a growing conviction that health care can be, and therefore ought to be, fully satisfactory in every instance, and that if the outcome is not satisfactory, someone is at fault."

Then he says: "Is that realistic? As a physician, I can only answer no. It is in fact hopelessly unrealistic."

Dr. Cooper thinks the basic cause for this dilemma is that physicians, at least in part, have allowed the public to overestimate what can be accomplished in medical care. In fact, he thinks the profession has, in some aspects, actively encouraged this viewpoint.

He is not critical of medicine for sponsoring the over-optimistically structured expectations, but rather presents the subject as an inevitable result. All therapeutic procedures, Dr. Cooper points out, must be presented and supervised with an expectant attitude—expectant of benefit. The fact that benefit will not always accrue is, of course, well known to the doctor, but should not be overemphasized to the patient.

Dr. Cooper suggests that the remedy is as complicated as the problem. It consists of public education by a multitude of informed sources. It will involve the careful and painstaking efforts of many disciplines. It may require changes in the law.

He feels that the cure of high expectations should start in medical school. He thinks the public should be informed as to who pays for unnecessarily high and totally un-

necessary legal judgments. He recommends that measures should be adopted to change social attitudes.

The title of his address was "Who Is Liable?" He concludes by saying that he doesn't see the problem as belonging to the government, to medicine, to the courts or to the legal profession. "We all contribute to it. Who is liable? Society is! If we can recognize that, then perhaps we can work to solve this problem."

Industrial Noise

PRINTERS, at least in the old days, learned early in life to talk on their hands. This was a great convenience when working close to a printing press. It also proved to be a godsend when, later in life, printers found themselves almost totally deaf because of the noisy working conditions.

Industrial noise has been a gradually increasing concern for many years. The concern is still increasing and the means of controlling the condition is improving.

Agricultural work has become too noisy for comfort. Agricultural colleges such as Purdue University are active in research on the subject and in providing protective devices for farmers.

Stanford Research Institute reports that an article in "Investments in Tomorrow" reviews the problem in industry. Besides printing presses and foundries, the author, Dr.

James Young, cites food processing plants.

The Occupational Safety and Health Administration (OSHA) sets 90 decibels as the maximum allowable noise level for an eight-hour work day. Higher levels are legally allowable for shorter periods of time. Young says 90 decibels is about as loud as a subway train going thru a station. A sensitive individual may suffer definite hearing loss on eight-hour-a-day exposure to 90 decibels for several years.

Labor unions are interested in the problem, naturally. The OSHA requires that noise be reduced wherever possible by engineering controls. This is not the most popular remedy because the elimination of noise is like the elimination of atmospheric pollution—expensive.

However, elimination of noise, to the greatest practicable extent, is still necessary. Protective devices for the ears, such as plugs and muffs, are not too reliable. Some are poorly designed, all are difficult to fit properly, workers may neglect to wear them and most of them are subject to displacement during work hours.

Meanwhile, a lot of people are working on the problem. With some more time industry may be able to achieve the ideal solution. Young thinks it possible to devise automated procedures that would not be too noisy and at the same time would increase the cost effectiveness of the manufacturing operation.

Cadmium An Environmental Threat

SOME rare metals can be so rare and so difficult to trace that almost nothing is known in regard to their behavior in the natural biological cycle. Cadmium is an example.

Research at Purdue University under Professor Yost is dedicated to removing the mysteries associated with cadmium, which is a toxic element although humans can tolerate small amounts.

Cadmium is found naturally in the soil and is used extensively in

the plating industry. The cadmium in coal is released into the atmosphere when coal is burned.

Intake of the metal so far as man is concerned is of two types, oral and respiratory. The big difference between the two is that cadmium intake in food and water is not so serious as the atmospheric portal. This is because a great deal of gastrointestinal cadmium goes straight through, that absorbed by the lung, while small as compared to the oral intake, is retained in the body practically 100%.

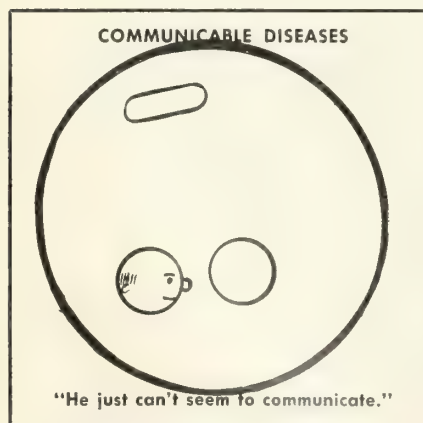
The nature of the toxic effects of cadmium is not well established. There is (or was) a small Japanese community which was decimated, apparently because the water supply of the village was entirely obtained from a river which was downstream from mining operations.

There may be a causal relationship between cadmium and an inclusive group of diseases, such as cancer and cardiovascular and respiratory ailments. This is supposition, but is based on the fact that the incidence of these ailments is significantly higher in industrial areas and may be due to cadmium contamination from coal-burning industry.

The main problem now is to discover how to avoid increasing the dosage that everyone automatically receives. We can't avoid it by moving out of the neighborhood. The content in food and water is there and always will be.

The Purdue researchers are looking for ways to prevent any higher degree of content in the water. Another item to consider is the build-up of cadmium in sewage. With the use of sludge for fertilizer the orally ingested cadmium which, for the most part, goes straight through, may provide a higher and higher level in plant life and food. Industrial wastes drained into sanitary sewers will also increase sewage cadmium.

The World Health Organization lists a maximum allowable intake of approximately 480 micrograms. On this basis Americans are up to 80%



of the allowance on the basis of food intake alone.

There is no evidence that the intake is increasing. Purdue researchers intend to solve enough of the unknowns in the equation to make possible a sensible cure for the problem if the food content of cadmium does increase.

The world is on the way toward reliance on coal to ever-increasing levels. This won't help the cadmium situation. There may come a time when sewage and sludge will be tested for cadmium level and not used for fertilizer if over the mark. Then a new place will be needed in which to throw it away.

Guest Editorial

To Run and Not Be Weary

Editor's note: We notice considerable public interest in physical activity as a means of preserving good health and would like to emphasize by these words of wisdom the further wisdom of cultivating such activity gradually and cautiously.

In his column of September 21 in the *Boston Herald*, Paul Benzaquin, columnist and radio "talk master," who offsets by a disciplined regimen of running his sedentary occupation of answering, for hours at a time, telephoned inquiries from his radio audience, tells of a middle-aged bagpipe-playing acquaintance who also got on the running kick only to find to his chagrin and pain that despite a powerful left arm and apparently inexhaustible lungs, his legs could not take the sudden dash into physical reconditioning.

Benzaquin reports, however, that his friend "went back to his exercise with supreme consideration for the muscles that couldn't match the lungs. Slowly and carefully, he built their endurance up to that of the mighty bellows. Now he's in good enough shape that he could play the pipes en route, except that the neighbors would certainly pelt him with clumps of peat, Scottish or native. . . his heart is in great shape,

his blood vessels throb with vitality, and he feels marvelous."

Dr. Paul Dudley White, impressed with the column, advised Benzaquin, "I think a summary of this ought to be in a medical journal because it is certainly more truth than poetry."

Those who have reached middle-age, or beyond, learned all too soon that their legs were the first part to go, and physically the rest of them was not far behind; to be envied are the Apostle Pauls and their dedicated followers who have the will to bike or run and whose vastus intermedius, lateralis and medialis and gastrocnemius and soleus muscles now take them painlessly in stride.

The rest wish that they could follow, for in their aging hearts they know that the persistent stalwarts are right, and that no amount of rationalizing can excuse them from not getting off their sedentary treadmill. Though the flesh may be heeding, the spirits are weak. It is in the mind, so to speak. They recognize the awful truth that they are in poor physical condition, and that their years may be lessened because of their reluctance to exercise regularly and systematically. But they cannot get themselves to take the first trot.

What is needed, admittedly, is an organization of dedicated Pauls (*Legs Anonymous*) who can counsel, cajole and inspire the rest of mankind to get off their collective seats and go a running.

Rabbi Ben Ezra's oft-quoted charge to the elderly, altered slightly, is pertinent:

Come run along with me!

The best is yet to be.—(and so forth).

—Reprinted, by permission, from *The New England Journal of Medicine*, 275:1253, 1966.

Editorial Notes . . .

Saccharin has had a checkered career. When Sucaryl was reported to have caused bladder malignancy in animals several years ago it was the cyclamate ingredient which was banned—the saccharin in Sucaryl

was not indicted. Since then both substances have been tested separately, as they should have been originally, and it is saccharin which has had slightly more worrisome reports. Now it is reported that an impurity, otho-toluene sulfonamide (OTS), may be the culprit. The FDA has dropped the permissible level of OTS to the lowest level detectable under current technology—25 parts per million, while awaiting the outcome of tests in Canada.

Upjohn reports research findings from University of Melbourne, Australia, on an asymptomatic and severe neonatal hypoglycemia. It occurs in offspring of insulin-treated mothers. Transplacental passage of insulin-antibody complexes interferes with assays of insulin, but the favored hypothesis is that elevated plasma insulin in the mother is the cause of early hypoglycemia in the fasting neonate.

A bill before Congress would amend the Medicare law to provide payment for medical services provided by physician extenders employed in a rural health clinic. "Rural health clinic" is specifically defined. Extenders are defined as physician's assistants, medex, nurse practitioners or any other practitioner who performs under the supervision of a physician and is authorized by the state and trained according to HEW standards. Such assistants can now be paid only when they perform services incidental to the services of a physician.

The New York Hospital-Cornell Medical Center is a teaching hospital of acknowledged excellence. Its utilization review chairman is quoted as expressing doubts concerning the cost-effectiveness of his committee's activities for the past year. The committee reviewed 9,500 charts in one year at a total cost of \$205,572. They identified six patients per year for which the length of stay was questioned. The cost of identifying each patient was \$34,212. Anyone for PSRO?????

The Nutrition/Health Information Center reports that a USC clinic observed improvement in blood cholesterol, triglyceride and blood pressure together with definite improvement of early sclerotic plaques in nine out of 25 patients treated for 13 months with diet and drugs. All of the 25 had Type II or Type IV hyperlipoproteinemia. Sixteen of the 25 had no reduction of blood findings; 13 had progression of their plaques, three showed no change. Most of the 25 had been referred to the university clinic by clinicians who had not been able to obtain any improvement by diet and drugs. Researchers regard the series as too small to be very significant, but wonder if the 16 patients who had no improvement really followed the diet and took the drugs.

Dr. Alejandro Zaffaroni of ALZA Corporation of Palo Alto, in his speech at the dedication of a new laboratory at Stanford Research Institute, expressed the opinion that, with the scarcity of new

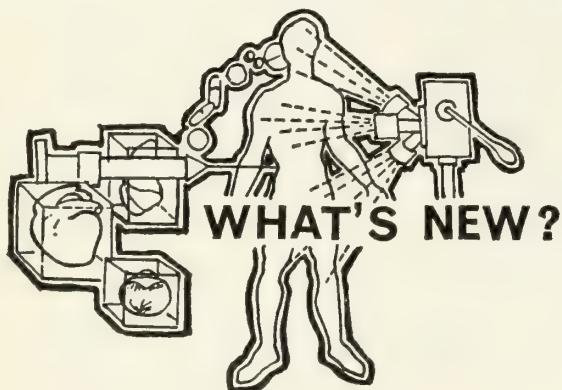
drugs, the therapeutic world needs more than ever a system for making the present stock of drugs more effective. Now the dosage, he says, peaks the blood level at the start and provides side effects, then subsides to a non-therapeutic level which fails to cure the ailment.

The advantages of an alert medical service in jails are emphasized in an observation of tuberculosis in the Cook County jail. After the diagnosis of a prisoner who had been incarcerated for several months skin tests on 107 fellow inmates lodged close to the active case showed that 23% were positive.

The Food and Drug Administration is publishing its final regulations for the professional and patient labeling of hearing aids. The effective date is now thought to be August 15. One condition for sale will be a medical evaluation of hearing within the past six months before sale. A signed statement by a physician must be presented to certi-

fy that a hearing aid will be of benefit. Persons over age 18 may waive the medical certificate if they are free of eight "red flag" conditions as determined by a thorough medical examination.

Metropolitan Life Insurance Company has compiled statistics concerning fatalities due to auto racing. All categories of racing, including dune buggy, snowmobile, motorcycle, drag, hill climb, etc., add up to thirteen. However, the number of drivers involved, which totals 364,881, is admittedly estimated and, since the miles driven in competition cannot be specified, the comparative value of the classification is not precise. The Indianapolis category lists 5,000 drivers with a 10-year total of 19 fatalities. The total number of drivers in all categories is probably not significant since many racers compete in more than one category. The grand total of 364,881 drivers accumulated a total of 436 fatalities in the period of 1967 to 1976.



Searle has a new non-sugar sweetener, Aspartame, which is awaiting FDA approval. It may turn out to be a substitute for saccharin. May be used in soft drinks, confections and other foods and in granulated sweeteners. It is a new type—made from two amino acids which appear naturally in many foods. It is metabolized in the same way as amino acids in food.

* * *

The Ames Company announces the CLINI-TEK®, which is a semi-automated bench instrument that reads eight different urine tests in less than a minute. Test results are displayed on a display panel by a system of diodes. It is thought to be more accurate since it eliminates such variables as operator timing and technic, lighting conditions and operator fatigue.

* * *

Cooper Laboratories is introducing a long-term comprehensive program devoted to the problem of patient non-compliance. The introductory booklet is now being distributed. Future booklets will focus on interviews with the pharmacist and nurse as well as the physician and patient. Each booklet will meet the criteria for one hour of credit in Category 5a for the Physician's Recognition Award of the AMA.

* * *

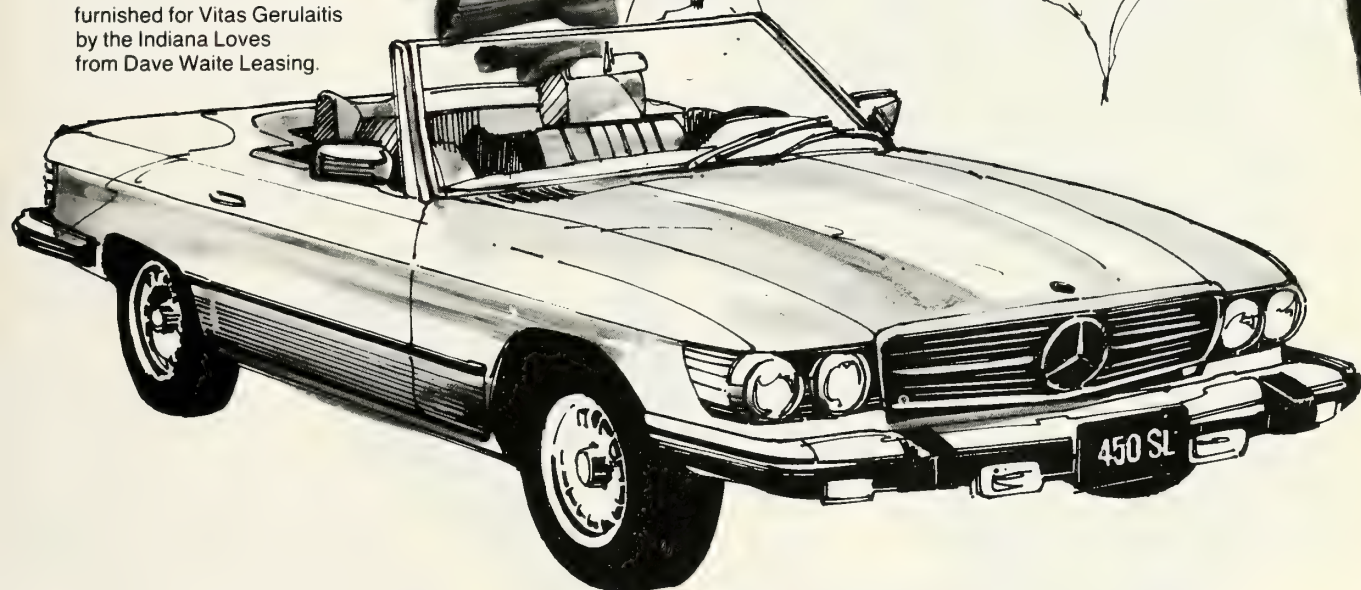
Resuscitation Laboratories announces the world's smallest cardiograph, the MINICARD. It is pocket sized, weighs less than one pound, and attaches directly to the chest by moistening the electrodes. No wires. It will instantly display the cardiogram on a 2-inch screen. Has adjustable scanning rate and will show heart rate when set for a scan of 12 or 25. It operates instantly when the start button is pushed and shut off in one minute to conserve batteries. Comes with a charger which takes either house current or automobile batteries as a power source.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

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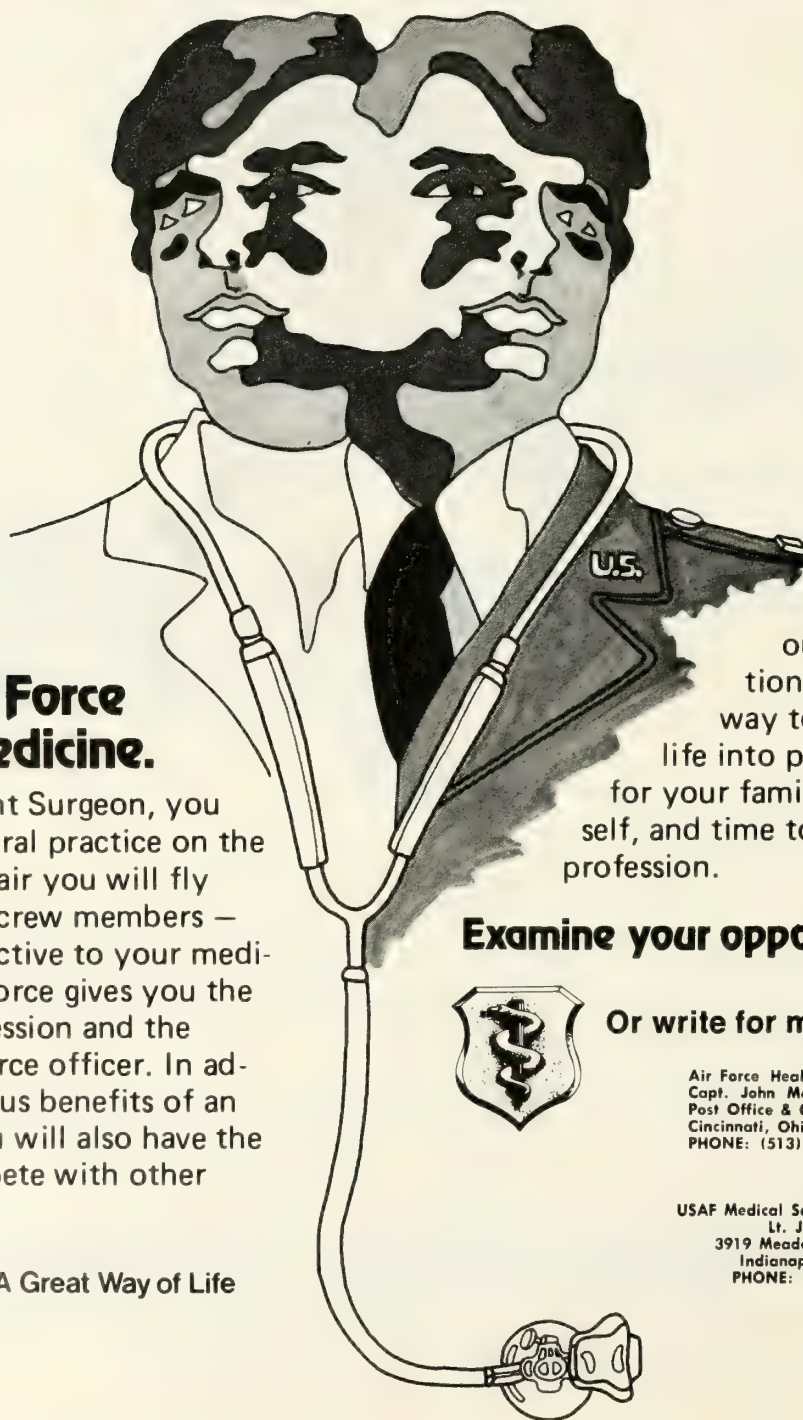
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BOOK REVIEWS

BASIC AND CLINIC IMMUNOLOGY

H. H. Fudenberg, D. P. Stites, J. I. Caldwell, J. V. Wells, Lange Medical Publications, Los Altos, Calif., 1976; \$12.50.

As a clinician with a peripheral interest in immunology I found this Lange publication too comprehensive to read word for word. It will make a fine reference book when specific questions arise; for instance, in tumor immunology or tests for Immunoglobulin E in allergy cases. So this review is written with one qualification in mind—I didn't read the whole volume nor will I in the future.

Although in soft cover, this is a big book. There are 2 columns of seemingly small print covering 611 pages with an appendix (including a glossary, acronyms and index) of 52 pages. Perhaps 50 authors have contributed chapters and these include the 4 editors. The subject seems comprehensively described from Basics (10 chapters) and Immunobiology (13 chapters) to Immunologic Laboratory Tests and, finally, Clinical Immunology (17 chapters). The authors imply that this information represents only the tip of the iceberg. The burgeoning of knowledge in Immunology is indeed impressive.

Frankly, there is an overwhelming body of relatively new knowledge here and acquiring it would be helped by a formal course of lectures by a professor. It is a valuable book to have in the doctors' library at your hospital.

RODNEY A. MANNION, M.D.
LaPorte

UNDERSTANDING ARTHRITIS AND RHEUMATISM

Malcolm I. V. Jayson, M.D., Allan Dixon, M.D., Dell Publishing Co., 1974.

This guide to the problems and treatment of arthritis and rheumatism was written for nonmedical readers by Drs. Malcolm Jayson and Allan Dixon. It is well illustrated and written in a clear, understandable style. It accomplishes its purpose of presenting to the laity, especially the patient with joint disease, the essential facts on the subject and what can be done about it. It is strongly recommended.

W. D. SNIVELY, JR., M.D.
Evansville

THE DIABETIC'S SPORTS AND EXERCISE BOOK: HOW TO PLAY YOUR WAY TO BETTER HEALTH

June Biermann, Barbara Toohey, J. B. Lippincott Co., Philadelphia, 1977; \$10.95 in hard cover; \$5.95 in soft cover.

During my 40 years of active practice in Internal Medicine, with special interest in diabetology, I explored all the various

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methods of treatment of diabetics and the associated physical activity which is so important in maintaining better control of the individual diabetic and lessening the amount of medication needed. It is recognized that exercise does reduce the requirements of either the oral tablets or insulin. The direction of the responsibility of the attending physician and, with the hectic schedule, most doctors do not have the time and opportunity to pursue the training of the patients and they are referred to various classes, clinics and group studies for this very necessary part of the treatment. The recent publication (being reviewed) is the answer to the problem of diabetes and exercise and is the most complete and clearly written document I have seen. It is the answer to the busy doctor and the frustrated diabetic.

When we consider that about 6% of the total population in this country are diabetics, the long-standing idea that the diabetic is basically an invalid and must be considered as an abnormal person with a vague complex of psychic aberrations should be corrected. The average diabetic can lead a normal life, be productive, can assume all types of activity, both social and work-wise, and can maintain a useful existence.

The overall picture of the need of all diabetics to participate in some form of exercise for the benefit of maintaining muscle tone, less medication, nearly normal diet, better control of the weight—whether too much or too little—and the eventual release of the emotional conflict and the psychic manifestations is well delineated. There are extremists who seem to believe that diabetes mellitus is basically a psychosomatic disorder and that the appearance of the disease may be part of a diffuse response to noxious psychic stimuli. Other cyclopic extremists seem to feel that there is no psychic component either as a precipitant or a resultant of the disease. This is to be expected in a disease of unknown etiology such as diabetes mellitus. Among the chronic and incurable diseases, diabetes mellitus is unique in many ways. Very frequently, the first few years of the disease produces no appreciable symptomatology. Therefore, when the metabolic deficiency is

discovered on routine investigation, the incentives of relief of discomfort and attainment of normal physical activity are lost as representing the rewards of good control.

As noted, exercise is important and the authors have defined the type of exercise consistent with the age, sex, ability and basic body structure and this applies to all diabetics, from those who are limited to simply home activities to those who are actively engaged in professional sports.

This book is extremely interesting and should be reviewed by all practitioners who treat diabetes and should be part of the training and constant reference of all diabetics.

IRVIN W. WILKENS, M.D.
Indianapolis

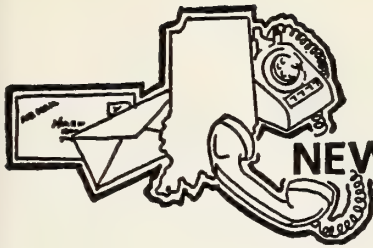
MEDICAL AND HEALTH ANNUAL 1977

Pope, Richard, editor, Encyclopedia Britannica, Chicago, 1976.

Any publication stemming from Encyclopaedia Britannica would be expected to attain high standards of quality, and this volume certainly does. In accordance with the Britannica tradition, this volume is written and edited for the layman by authorities in the field. Its scientific authenticity is impeccable. The writing is such that it can be understood by the average layman. Illustrations are in full and sumptuous color. Representative chapter titles include "Medical History," "The Medical Magic Show," "The Concept of Health," "Childhood Illnesses," "Death," "Hemodialysis," "Radiation Injury," "World Medical News" and so on. It can be highly recommended for the nonmedical person desiring medical information in an authentic and attractive form. The volume is attractively bound in artificial leather, with 448 pages. Distributed to book stores by Hammond, Inc., the cost is \$14.95.

W. D. SNIVELY, JR., M.D.
Evansville

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2	3	4	5	6	7	8
9	10 <small>Columbus Day</small>	11	12 <small>Traditional Columbus Day</small>	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
ISMA 1977 ANNUAL MEETING Hyatt Regency Hotel • Indianapolis						
30	31	NINETEEN SEVENTY-SEVEN				



NEWS NOTES

"The Newborn" Television Series On WAT 21 First Tuesday of Month

Physicians, nursery personnel and respiratory therapists can now take advantage of a new series of television programs called "The Newborn," hosted by Richard Schreiner, M.D.

Telecast by WAT 21 Medical Television at 12 noon (Indianapolis time) the first Tuesday of each month, "The Newborn" features formal presentations on care of the newborn followed by informal two-way discussions with viewers at WAT 21-served hospitals. Dr. Schreiner, a neonatologist at James Whitcomb Riley Hospital for Children, stresses that these live discussions are not limited to the formal topic of the day but may deal with any aspect of newborn care, both for the normal and high risk infant.

"The Newborn" premiered in February and will be telecast year 'round with the following topics scheduled for the summer months: "The Use of Nasal CPAP," "Breast Feeding: Prenatal and Postpartal Preparation," "Physical Examination of the Newborn" and "The Premature Infant: Is It Worth It?"

Although WAT 21 reaches 28 major hospitals, more than 90 hospitals in the state have the 3/4" videocassette machines necessary for playing back these programs. Most titles will be available for free loan to Indiana physicians. The first four now available are entitled: "Infants at High Risk: Resuscitation" (Mead Johnson and University of Pennsylvania), "Techniques of Arterial Blood Sampling" (IUSM), "Birth Trauma" (IUSM) and "Determining Gestational Age" (IUSM).

Inquiries should be directed to the WAT 21 Station Manager, University Hospital A116, 1100 W. Michigan St., Indianapolis 46202.

Blue Shield Officers, Directors Chosen

Dr. Joseph M. Black, Seymour, has been reelected chairman of Blue Shield. **Dr. John Paris, New Albany**, was elected vice-chairman; **Dr. John Beeler, Indianapolis**, secretary, and **Frank E. McKinney, Jr., Indianapolis**, treasurer. **Dr. Gilbert Wilhemus, Evansville**, was elected to succeed **Dr. Peter Gutierrez, Crown Point**, as director.

Reelected to three-year terms on the Board of Directors were **Drs. Ralph F. Carlson, Evansville**; **G. Beach Gattman, Elkhart**; **Peter Petrich, Attica**; **William L. Strecker, Terre Haute**; **Harry D. Tunnell III, Fort Wayne**, and **Donald L. Taylor, Muncie**; also **Mr. James A. Perkins, Indianapolis**, and **Mr. John O'Connor, Carmel**.

New First Aid Film Available

Association Films, 866 Third Ave., New York City 10022, has a film available on a free loan basis or for sale. It was sponsored by Johnson & Johnson and presents a new perspective on first aid training. The title is "Prepared to Care." It provides an excellent exposure to the first aid skills which could and should be learned by everyone.

Discusses Indiana's Malpractice Law

Dr. Gilbert M. Wilhemus, Evansville, addressed a recent meeting of PM Indiana, Inc. at Lafayette. His topic was Indiana's malpractice law as now in force, changes that may be needed, and its constitutionality.

International Physicians to Convene

The American College of International Physicians, an association of foreign medical graduates, will hold its second annual convention in Chicago Sept. 3 and 4. The College was registered and incorporated in Indiana. **Dr. Hanus Grosz, Indianapolis**, is president, **Dr. Wei Ping Loh, Gary**, is president-elect, **Dr. Jesus Bacala, Scottsburg**, national secretary and **Dr. Jose Tord, Indianapolis**, treasurer.

Ortho Producing Family Planning Spot Announcements for Television

The Ortho Pharmaceutical Corporation has produced a public service television spot announcement to teach the facts about various methods of family planning. The 60-second message counsels women to learn all the facts and consult their doctor. The tape is being distributed to over 400 commercial TV stations.

Film on How to Use a Fire Extinguisher

The National Fire Protection Association has for sale a new full-color moving picture film "Using Fire Extinguishers—The Right Way." They won't work unless you use them right. Both 16 mm films and video cassettes are available. Introductory price is \$165, effective until April 15.

Chapel Renamed to Honor Dr. Klepfer

The All Faith Chapel at Richmond State Hospital was recently rededicated and renamed to honor **Dr. Jefferson Klepfer**, who died in 1976 after serving for 25 years as medical superintendent of the hospital.

Hospital Medical Staffs Elect

Margaret Mary Community Hospital, Batesville—**Dr. Ali Daftary**, chief of staff; **Dr. Edgardo Ortiz**, secretary.

St. Mary Mercy, Gary—**Dr. Earl J. Mason**, chairman of the executive committee.

Union Hospital, Terre Haute—**Dr. Byron C. Wheeler**, president; **Dr. Pandeli Anas**, chief of staff; **Dr. William J. Mankin**, vice president; **Dr. Greg L. Darrow**, treasurer, and **Dr. Y. S. Chau**, secretary.

Schedule for Upcoming NCME Programs

The Network for Continuing Medical Education Announces the following schedule of programs:

June 13-July 10 "ATOPIC DERMATITIS AND THE BETA ADRENERGIC THEORY," with **Andor Szentivanyi, M.D.**, chairman, Department of Pharmacology, and professor of pharmacology and internal medicine, University of South Florida, Tampa, and **E. William Rosenberg, M.D.**, professor of dermatology and associate dean, School of Medicine, University of Tennessee, Memphis.

"EVALUATING PATIENTS WITH OCCLUSIVE CEREBRO-VASCULAR DISEASE," with **Noble David, M.D.**, chief, Neurology Service, Miami Veterans Administration Hospital, and Professor of Neurology, University of Miami.

Dr. Heritier Attends World Meeting

Dr. C. Jules Heritier, Columbia City, attended the 30th annual meeting of the World Medical Association in Sao Paulo, Brazil, recently. Theme of the meeting was "Pollution and Society."

Dr. John Suelzer Wins Jefferson Award

Dr. John G. Suelzer, Indianapolis, was one of 10 Hoosiers selected to receive the first Indiana Jefferson Awards honoring distinguished public service. The winners will be considered for the national awards, dedicated to President Thomas Jefferson by the American Institute for Public Service. More than 400 Hoosiers were nominated.

An orthopedic surgeon, Dr. Suelzer, 45, was "a major force in development of the Marion County emergency ambulance program from one that limped along with poorly maintained vehicles to a modern system featuring super-ambulances and para-professional crews." Dr. Suelzer has been chairman of the Governor's Commission for Emergency Medical Services. As chief medical officer for the Indianapolis Fire Department, a \$1 a year job, Dr. Suelzer is required to respond to major fires on a round-the-clock basis.

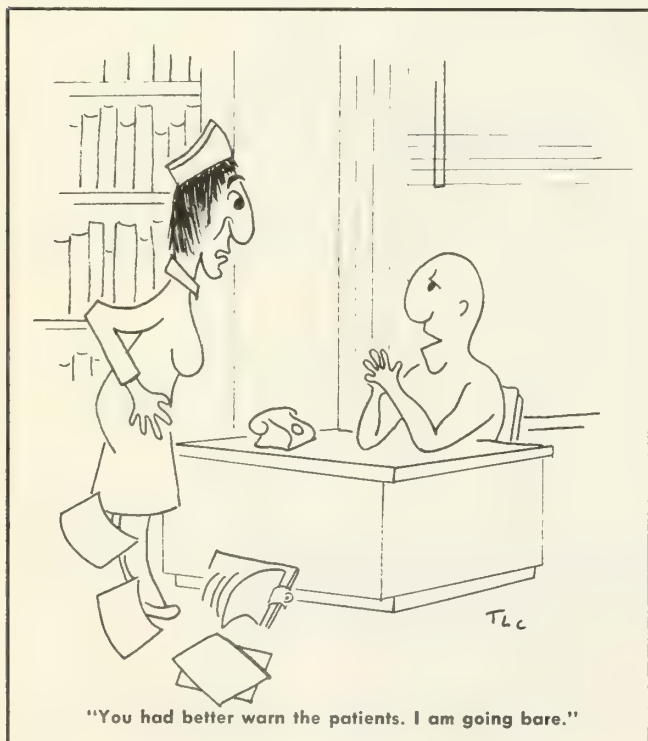
Dr. Steen Appointed JCAH Commissioner

At a recent meeting of the Board of Trustees of the American Medical Association Dr. Raymond T. Holden, board chairman, appointed Dr. Lowell Steen, Hammond, to a three-year term as a commissioner to the Joint Commission on Accreditation of Hospitals.

Dr. Sprague Gardiner of Indianapolis is also a commissioner.

Twelfth Scientific Session Held

The Indiana Philippine Medical Association held its 12th Scientific Session at Scottsburg on Mar. 27. The session was devoted to "The Many Faces of Private Practice." Five and one-half hours of Category 1 credit was granted to the program.



What's New?

Eli Lilly announces that Nalfon® (fenoprofen calcium) now includes in its indications the treatment of osteoarthritis in addition to the symptomatic treatment of rheumatoid arthritis. Less joint pain and reduction of objective findings are observed along with the demonstration that the drug is usually well tolerated.

* * *

Mead Johnson announces Deapril®ST, a combination of three dihydrogenated ergot alkaloids, for the treatment of symptoms of the elderly such as moderate mood depression, unsociability, confusion, dizziness and lack of self care. It is marketed as 1 mg sublingual tablets.

* * *

CLINITEST reagent tablets by Ames are now packaged in round bottles—greater convenience for the diabetic patient. Package sizes are 100s with child-proof-cap; 100s with exclusion, non-child-proof-cap; and 250s for hospital and laboratory use.

* * *

Searle Laboratories has a new disposable uterine sound. Called the Mark 7, it is dispensed in individual sterile packaging. It has a narrow shaft and a sliding collar which, when positioned against the cervix after complete introduction, will indicate the depth of the cavity.

* * *

Stebco Industries has a new Hydro-Static Cushion for wheelchair patients. It aids in preventing decubitus ulcers and assists in treatment. It is filled with a layer of water. Made of durable fabric, vinyl-backed. Has an interior construction which prevents swaying. Large dump valve for ease in filling.

* * *

AMACOM, a division of American Management Associations, has published a book for physicians. Title is "Doctors as Managers of Health Teams: A Career Guide for Hospital-Based Physicians." It deals with how to work with hospital politics, how to reduce bureaucratic red tape, how to handle budgets and how to protect the patients from the faults of the multi-departmental system. 271 pages. \$15.95.

* * *

Spectroderm International announces a Vacuum Guard for the protection of vacuum lines against biological contamination. It provides air filtration for vacuum lines and interrupts the vacuum if biological fluids are drawn toward the line. Operates on a 12-volt battery. If biological solutions are inadvertently drawn toward the line, a red light goes on. When the entering lines are clear, a green light shows. Ideal for radioimmunoassay.

* * *

Corning Medical announces a booklet, which may be obtained free of charge, explaining the Uni-Yeast-Tek system for identifying 18 of the most frequently isolated clinical yeasts. Georgia State University, working with cultures from the CDC, obtained a 99.8% correlation between this system and conventional yeast identification methods. Write Corning Medical, 25 Lumber Road, Roslyn, N.Y. 11576.

Hyatt Regency Site for 1977 Convention

PLANS for the 1977 annual convention of the Indiana State Medical Association are getting well under way, according to Victor H. Muller, M.D., Indianapolis, chairman of the Commission on Convention Arrangements.

Dates for the meeting are Oct. 23 through 26 at the spectacular new Hyatt Regency hotel which opened in April. All events will take place there, including the House of Dele-

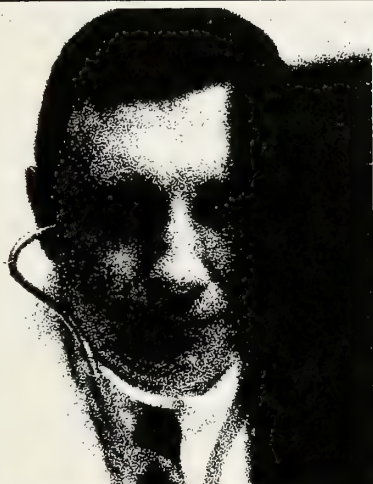
gates, Reference Committee Meetings, Section Meetings and general scientific sessions.

The new hotel is located on the site of the former Lincoln Hotel at the corner of Washington Street and Capitol Avenue, just across the street from the State Capitol. There is ample parking space and easy access to all the downtown area shops and restaurants.

The medical theme of this year's

Convention is "Infectious Diseases." All general sessions, section meetings and the annual "Meet the Professor" sessions will incorporate the theme into programs. As usual, postgraduate education hours will be awarded to those who attend the scientific sessions.

Make your plans today to attend the forthcoming meeting. Watch **THE JOURNAL** for more specific details.



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FUTURE MEETINGS, SEMINARS, COURSES

Endocrinology Course at Indianapolis

"Endocrinology" will be the subject of a postgraduate course to be sponsored by the American College of Physicians at the Indianapolis Hilton Hotel on June 1 to 3. The course will review information in the fields of endocrinology and metabolism, recent diagnostic and therapeutic advances. Write Dr. C. Conrad Johnston, Jr., I.U. School of Medicine for full particulars.

Kentucky Slates Conference On Clinical Uses of CEA

An International Conference on the Clinical Uses of Carcino-embryonic Antigen (CEA) will be conducted on June 1 to 3 at the Hyatt Regency, Lexington, Ky., under sponsorship of the University of Kentucky. The registration fee is \$75. Approved for 16 hours Category 1 credit for AMA Award. Write Frank R. Lemon, M.D., College of Medicine, Lexington 40506.

Human Sexuality Program July 20-29

"Institute for Sex Research," the 8th Annual Summer Program in Human Sexuality, will be conducted at Indiana University—Bloomington, July 20 to 29. To be conducted by ISR

staff and distinguished guest lecturers. Registration fee is \$315. The course is designed for individuals in the health professions and related fields. Write the Institute at 416 Morrison Hall, Bloomington, Ind. 47401.

Family Medicine Review at Lexington

"Eighth Family Medicine Review" Session I will be from Oct. 2 to 7, Session II from Oct. 23 to 28, at the Hyatt Regency, Lexington, Ky. It is rated for 50 hours of AAFP credit and Category 1 AMA Award credit. Registration fee is \$295. Write Frank R. Lemon, M.D., University of Kentucky, Lexington 40506.

October Workshop at Gatlinburg on Melanomas, Non-Hodgkin's Lymphomas

"Cancer Concepts 1977" is the theme of a continuing education program to be held Oct. 16 to 18 at the Sheraton Inn, Gatlinburg, Tenn. It is a three-day accredited workshop focusing on the latest diagnostic and treatment technics in care of Melanomas and Non-Hodgkins Lymphomas. Write Dr. Harvey Goodman, University of Tennessee Center for the Health Sciences, 1924 Alcoa Highway, Knoxville 37920.

From THE JOURNAL 50 Years Ago

In former years probe puncture of the antrum of highmore was resorted to principally in determining the presence or absence of purulent secretion in acute and chronic infections of this cavity. While it is true that the same procedure is employed today for exactly the same indications, we have observed in our own practice during the past few years, a number of interesting results from the above procedure where purulent secretion was not found.

All of us, I am sure, are consulted from time to time by patients complaining of headaches, moderate to severe, occurring primarily in the early morning hours. This we have been taught by experience to be rather suggestive of intranasal pressure, or sinus pathology. In a number of such cases, where no marked intra nasal pathology was demonstrable, as marked deflected septum, hypertrophied middle turbinate causing pressure on the lateral wall or septum, and the presence of purulent secretion in any meati or in the naso-pharynx, the probe puncture and irrigation of one or both antra, depending on the symptoms present, has brought complete relief of all headaches. In none of these cases where relief was obtained was purulent secretion recovered in the washings. . . .

In conclusion, I would recommend that probe puncture and irrigation of the antra be resorted to more frequently both in children and adults. Carefully performed through the inferior meatus at its highest point, puncture of the antrum is a safe procedure if all precautions are taken, and the results obtained in many cases certainly justifies its frequent use. . . . B. D. Ravdin, M.D., Evansville, "Diagnostic Puncture of the Antrum of Highmore," JISMA, May 1927.

Deaths

Harold C. Adkins, M.D.

Dr. Harold C. Adkins, retired Indianapolis physician, died Mar. 19 in Winona Memorial Hospital. He was 74.

Dr. Adkins was a 1928 graduate of Indiana University Medical School and served his internship at Harper Hospital. His office was in Indianapolis from 1929 until his retirement in 1976.

A World War II Army veteran, Dr. Adkins was a member of the Marion County Medical Society and the American Medical Association.

Maurice M. Best, M.D.

Dr. Maurice M. Best, New Albany, died Mar. 9. He was 57.

A graduate of the University of Louisville Medical School with the Class of 1945, Dr. Best was professor of medicine at the University of Louisville and was cardiologist at Floyd County Memorial Hospital.

He was a Fellow of the American College of Physicians and a member of the American Medical Association as well as the Floyd County Medical Society.

Robert W. Donnelly, M.D.

Dr. Robert W. Donnelly, 62, Indianapolis, died Mar. 27 in Wishard Memorial Hospital following an auto accident.

After his graduation in 1941 from the Indiana University School of Medicine, Dr. Donnelly interned at Christ Hospital Cincinnati, and served his residency at St. Luke Hospital, Chicago. He was certified by the American Board of Radiology in 1953.

He was on the medical staff of St. Francis Hospital and University Heights Hospital. Prior to moving to Indianapolis, Dr. Donnelly was head of the radiology department at Lakeview Hospital, Danville, Ill., for 10 years.

Dr. Donnelly served two years in the European Theatre in World War II.

His memberships included the American College of Radiology, American Medical Association and Marion County Medical Society.

Robert F. Jeans, M.D.

Dr. Robert F. Jeans, Richmond psychiatrist, died Mar. 17 at Reid Memorial Hospital. He was 52.

A 1949 graduate of the University of Illinois College of Medicine, Dr. Jeans interned at the university's Research and Educational Hospital and was a resident at Michael Reese Hospital, Chicago. Licensed in Indiana in 1953, Dr. Jeans was certified by the American Board of Psychiatry in 1959.

He was a member of the Wayne-Union County Medical Society and the American Medical Association.

Roy R. McCoy, M.D.

Dr. Roy Ralston McCoy, Fort Wayne, died Mar. 22 in Mesa (Ariz.) Lutheran Hospital. He was 67.

Dr. McCoy graduated from Indiana University Medical School in 1939 and had been in practice at Fort Wayne following an internship at Indianapolis General Hospital and a residency at Pontiac City Hospital, Pontiac, Mich.

He was a member of the Allen County Medical Society and the American Medical Association.

Harry C. Parker, M.D.

Dr. Harry C. Parker, 89, retired Gary otolaryngologist, died Mar. 28. He had resided in Hobart for 25 years.

He graduated from Northwestern University Medical School in 1911 and interned at Hackley Hospital, attaining certification in otolaryngology in 1930.

A senior member of the Indiana State Medical Association, Dr. Parker became a member of the 50-Year Club in 1961.

R. Perry Reynolds, M.D.

Dr. R. Perry Reynolds, 67, former Garrett physician, died in a San Diego Hospital Feb. 11. He had been a resident of San Diego since 1961 and was the associate medical director of the Camarillo State Hospital at the time of his death.

In 1937 he graduated from the Indiana University School of Medicine, and in 1938 he opened an office in Elizabethtown, moving to Garrett in 1941. He was a former member of the DeKalb County Medical Society and the American Medical Association.

William C. Vance, M.D.

Dr. William C. Vance, Terre Haute, died Mar. 6 at home. He was 69 and retired in 1976 from Indiana State University's Student Health Center, where he served as the university psychiatrist for 12 years.

A veteran of World War II, Dr. Vance was a 1934 graduate of Indiana University School of Medicine. He was a diplomate of the American Board of Pediatrics and a Fellow of the American Academy of Pediatrics. A former member of the Wayne-Union County Medical Society, Dr. Vance was a member of the Vigo County Medical Society and the American Medical Association.

Victor I. Varner, M.D.

Dr. Victor I. Varner, Evansville, died Mar. 15. He was 83 and had retired in 1945.

A veteran of World War I, Dr. Varner was formerly a member of the Vanderburgh County Medical Society.

Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of **The Journal**. Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.

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In Brief . . . A Summary of AMA Medical and Health News

Four medical schools have stated publicly they will refuse federal capitation assistance rather than be forced to accept U.S. citizens from foreign medical schools. The four schools planning to oppose the forced-transfer provision of the new health manpower bill are Indiana U., Yale U., Stanford U., and Wright State U. in Dayton.

Commenting on a report by Ralph Nader's Health Research Group proposing a national Medicare fee schedule for physicians, AMA Board of Trustees Chairman Raymond T. Holden, M.D., said: "The truth is that Medicare and Medicaid have not paid a fair reimbursement since 1971. While physicians must pay their office staffs at 1977 wage levels, and heat their offices at 1977 fuel prices, and buy professional liability insurance at 1977 premium rates, the government reimburses them at 1975 fee levels." He said the report's proposal to give HEW authority to withdraw hospital privileges of physicians who do not accept Medicare and Medicaid patients "constitutes a repugnant exercise in coercion, a clear abuse of federal power."

COMMERCIAL ANNOUNCEMENTS

NEW BUILDING being built at 4543 Lafayette Road, near Lafayette Square shopping center. Also space in Clermont, Ind. D. E. Tavel, 293-5424.

OTOLARYNGOLOGIST and Physical Medicine Rehabilitation, trained at McGill University, seeking relocation in Indiana. Write Box 413, The Journal, 3935 N. Meridian St., Indianapolis 46208.

EXCELLENT OPPORTUNITY and environment—physician needed to practice general medicine in large outpatient clinic and 38-bed fully accredited hospital. Must possess empathy toward college age population. Salary negotiable, excellent fringe benefits. Contact L. W. Combs, M.D., Purdue Student Hospital, West Lafayette, Indiana 47907. 317-749-2441.
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EXCELLENT OPPORTUNITY for physician desiring regular hours and ideal working conditions. Basic responsibilities are in the Medicaid Division and in the Public Assistance Division of the State Department of Public Welfare to review applications for assistance to the disabled. Enjoy a competitive salary and many fringe benefits. Please contact James O. Price, M.D., Indiana State Department of Public Welfare, telephone 317-633-5596.

CONFERENCES for Medical Professionals—A calendar listing of over 500 national/international meetings, conferences and seminars in the medical sciences for 1977. All medical specialties included. Send a \$10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

WANTED: PHYSICIAN FOR STUDENT HEALTH CENTER. Excellent facility including laboratory, x-ray and pharmacy. Position available July 1, 1977. Must be licensed to practice in the state of Indiana. Applications received after June 1, 1977, may not be considered. Contact John A. Hetherington, M.D., Director Student Health Center, Indiana State University, Terre Haute, Indiana 47809. Phone: 812-234-2646. ISU is an Equal Opportunity/Affirmative Action Employer.

DOCTOR: YOU CAN CASH IN the equity in your home—without moving or borrowing! Send for free details. CASH, Box 40215-M3, Indianapolis 46240.

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Large industrial facility, located in northwestern Indiana, has an immediate opening for a Medical Director. You will supervise a medical facility and experienced staff and play an active role on the management team. The position offers excellent salary and fringe benefits. M.D. required. Please reply to: Box 415, The Journal.

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Fast growing mental health center needs a Medical Director who would be responsible for supervision and coordination of all patient services, including inpatient, partial day care, and outpatient treatment. Excellent opportunity for a dynamic Psychiatrist interested in community mental health and seeking a challenge. Applicants must be Board Certified or eligible in Psychiatry and licensed to practice medicine in the State of Indiana. At least two years experience in a community mental health center field and/or experience working with multidisciplinary staff is preferred. Tri-City, located in Indiana, is in the greater Chicago area and within one-half hour's drive from downtown Chicago. Competitive salary and fringe benefits. Contact Richard E. McPherson, Center Director, Tri-City Comprehensive Community Mental Health Center, 3901 Indianapolis Boulevard, East Chicago, Indiana 46312, or phone (219) 398-7050.

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INDIANA — Creative Emergency Department Director to head up established Emergency Medicine group at 250-bed hospital; 20,000 patient visits; minimum guarantee/fee-for-service; \$60,000 plus fringe benefits including relocation, health insurance, profit sharing, vacation, educational leave, malpractice insurance. Contact T. P. Cooper, M.D., 1-800-325-3982.

PHYSICIAN — for full-time position at a large hospital for the mentally retarded in southeastern Indiana. Background in General Practice, Psychiatry, Pediatrics or Neurology would be appropriate. Forty hour week and generous fringe benefits. Six full-time physicians on staff, regular visits by consultants in most medical specialties, close affiliation with local community hospital, pleasant working atmosphere in an attractive section of Indiana. Send resume to: William Culley, Program Coordinator, Muscatatuck State Hospital, Butlerville, Indiana 47223.

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The JOURNAL

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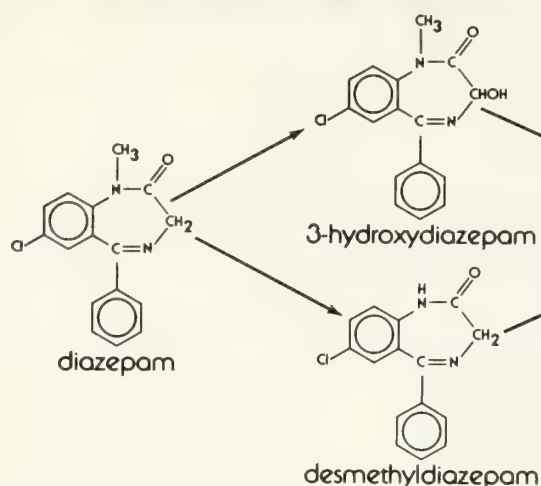


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Valium (diazepam) is a benzodiazepine with a distinctive pharmacokinetic profile

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**a prudent choice in psychic
tension and anxiety**

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due

to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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MEDICAL MUSEUM NOTES



FIGURE 1

This month's museum page features a building which is no longer in existence. When it was built in 1895 it was the Medical College of Indiana. When it was razed in 1961 it was the Statehouse Annex.

This was the largest of Indiana's proprietary schools, and the oldest of the three proprietary schools which united to provide a state-owned medical school for Indiana.

Figure 1 is a photograph of the oil painting of the school by Harry Davis. This painting, which measures approximately 6' by 4', now hangs on the front wall of the amphitheater, together with diplomas of the various medical schools which occupied the building: the Medical College of Indiana; the Department of Medicine, Purdue University; and Indiana University School of Medicine. Note that at that time the building was four stories tall, and that the 1869 found-

ing date on the decorative facade on the roof was formed of numerals several feet high.

The medical school moved to its present location in 1918. The State Board of Health and the State Highway Commission then took over the building, which was designated the "Statehouse Annex." The decorative facade on the roof was removed, and a fifth floor added.

The building proved inadequate to keep abreast of the growth of these two state agencies, and in the 1930s the Board of Health was moved to the I.U. Medical Center, leaving the Highway Commission to occupy the entire Annex.

Growth of all facets of state government ultimately brought into being the present State Office Building. This was constructed im-

mediately behind the Statehouse Annex (**Figure 2**).

Figure 3 shows the nearly demolished Annex flanked by the State Office Building on the left and the west entrance to the Statehouse on the right.

A large marble slab listing the names of the founders of the Medical College of Indiana was originally located in the entrance foyer of the College. This was removed and placed in the entrance hall of Emerson Hall on the Medical Center campus when the annex was added to that building in 1927. When that area was remodeled in the early 1950s, the marble slab was again removed and crated. It is currently in storage.

CHARLES A. BONSETT, M.D.
6133 E. 54th Place
Indianapolis 46226



FIGURE 2



FIGURE 3



MONTH IN WASHINGTON

THE CONGRESS HAS RECEIVED ITS FIRST MAJOR HEALTH BILL from the Carter Administration—a massive and complicated program for limiting hospital revenues to a 9 or 10% annual rise. Income from all inpatients, private as well as federal beneficiaries, would be affected.

Hospitals exceeding the allowable increase could be socked with a penalty tax amounting to 150% of the “overcharges.” Such offenders also would have to reduce charges the following year.

Physicians’ offices were not affected by the proposed legislation, though Health, Education, and Welfare Secretary Joseph Califano has indicated this is under study.

The hospital plan received the fanfare of a White House send-off, with a statement by President Carter and White House briefings of affected groups and of reporters. Contrary to some expectations, Carter did not use the plan as the keystone of a major health message to Congress, though he mentioned national health insurance.

Congressional hearings are expected to open in a few weeks on the hospital program. There’s no way the proposal will get through Congress unscathed, experts believe. The lawmakers have been pushing to brake the costs of Medicare and Medicaid, but a cost-control program involving an entire private industry is a different matter. There is almost no sentiment in Congress for a revival of wage-price controls for the economy as a whole.

At the insistence of organized labor, the proposal contains an exemption for hospital wage increases which, by itself, would appear to blow the 9% restraint out of the water. A hospital could adjust upward its permissible revenue by

This summary of what is happening in Washington is prepared by AMA’s Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

the amount of any wage increase.

Inpatient revenues of the 6,000 acute-care hospitals in this country are covered. Brand new hospitals, federal hospitals and hospitals controlled by Health Maintenance Organizations (HMOs) would be exempt.

The legislation also imposes a limit on new capital expenditures, fixing a national level for such expenditures below that of recent years and allocating new capital spending among the states by formula. With the assistance of local planning agencies, each state would determine how the hospitals can make capital expenditures.

States which operate cost containment programs which are capable of meeting the federal criteria could continue their own regulatory approaches.

The American Hospital Association charged that the control measure “would severely jeopardize the provision of hospital care to the American public.” Hospitals and physicians will unite in opposing it, the AHA said.

As Carter described his plan, “This legislation is not a wage-price control program. It places no restrictions on the hospital’s ability to determine its charges for any particular service. It places no limit on the size of any wage demand or settlement. The program establishes an overall limit on the rate of increase in reimbursements, permitting doctors and hospital administrators to allocate their own resources efficiently, responding to local needs and individual circumstances.”

Under the bill, the basic limit on increases in total inpatient-care revenues would be set by a formula reflecting general price trends in the economy as a whole, plus an additional amount to accommodate some increase in intensity of patient services.

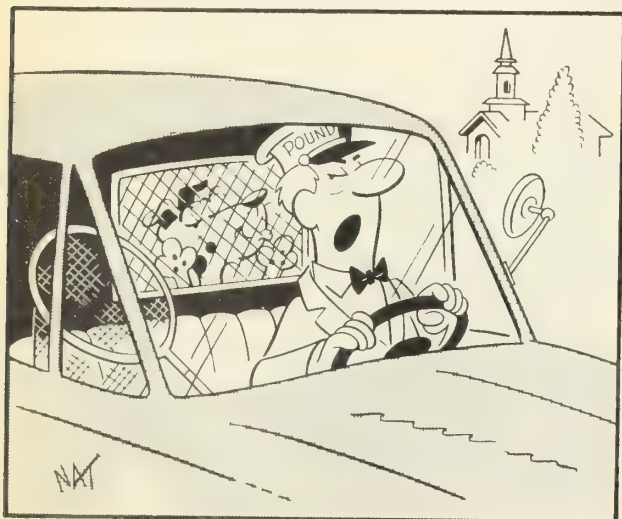
A CRUCIAL VOTE IS COMING SOON ON LEGISLATION to arm the Federal Trade Commission with strong new powers over business and to expand its authority over non-profit groups, including medical associations.

The full House Commerce Committee will be taking up a bill approved recently by the Subcommittee on Consumer Protection. The issue pits consumer against business interests with important implications for the medical community.

The FTC has been very active for more than a year in the medical field, taking actions against medical ethical advertising codes, relative value scales, antitrust inquiries about possible resistance to Health Maintenance Organizations (HMOs), challenging the validity of professional accreditation, among other moves.

Heretofore, the Agency has not had the power to act against non-profit associations without contending that it is dealing with aspects that are essentially commercial. The bill before the House Commerce Committees would for the first time make non-profit, professional groups a clear responsibility of FTC.

The American Medical Association has urged that non-
Continued on page 286



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androgenic deficiency
is driving them apart



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New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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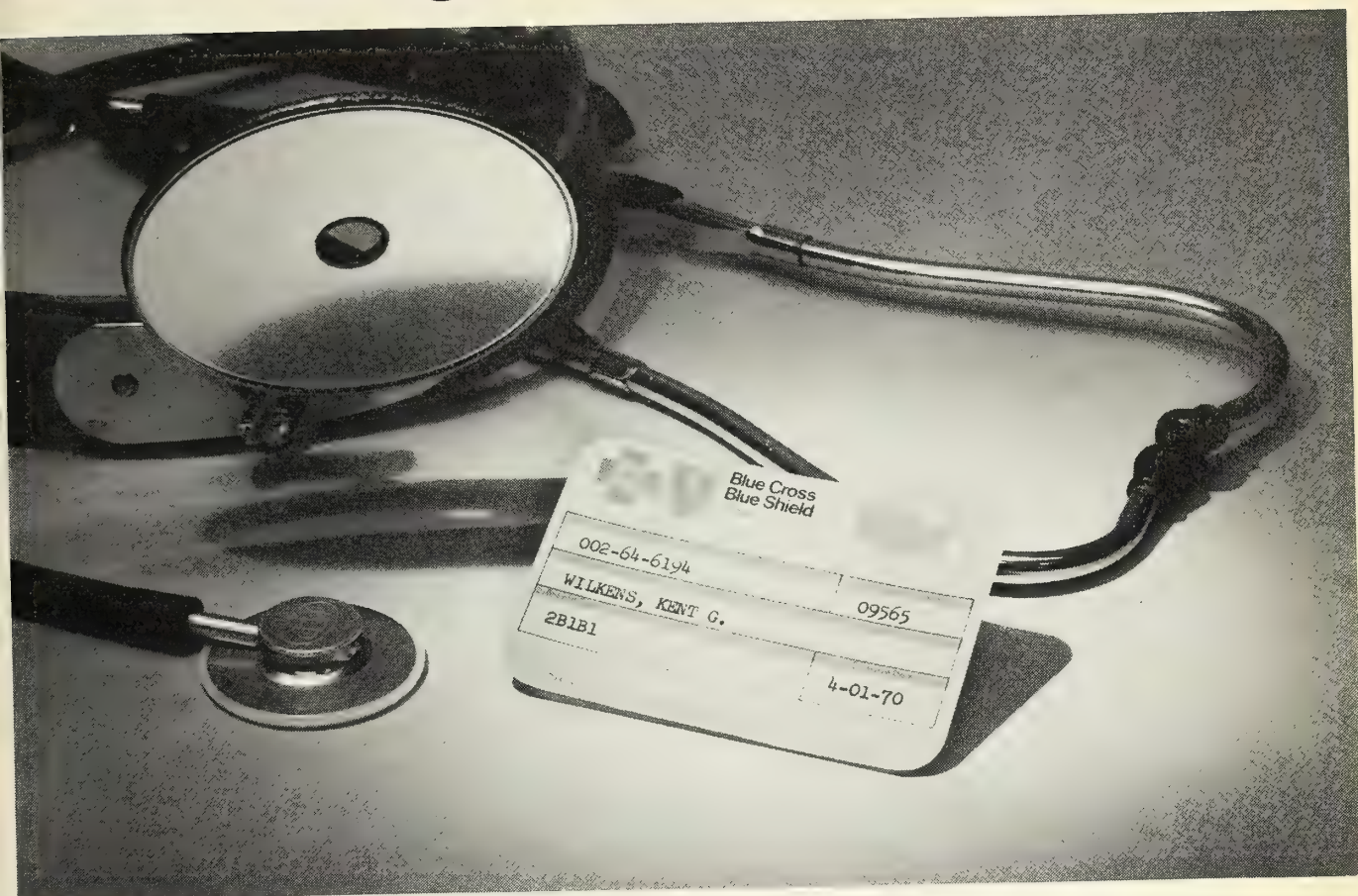
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profit organizations not be placed under FTC control.

Under H.R. 3816, the FTC could seize the assets and records of non-profit associations, and levy fines up to \$5,000 per day. The AMA warned that this extreme power was being granted, not to the normal repository of such authority—the judiciary—but rather to a federal agency.

THE NATION'S HEALTH SHOWS STEADY IMPROVEMENT, according to a 25-year mortality survey by the National Center for Health Statistics.

Since 1950, the death rate from stroke and heart disease declined steadily in those aged 25 to 74 and deaths from tuberculosis, once a leading cause, now number 3,000 annually.

Dorothy Rice, the Director of the Center told the Senate Health Subcommittee, "the spectacular decline in death rates from heart disease may well reflect improvement in medical care . . . there appears to have been reduction in the incidence of heart disease during this period of sharply declining mortality."

The mortality rate from heart disease dropped 30% in those aged 45 to 74, with the biggest gains coming in the last six years.

The death rate from stroke fell even more sharply during this period—a 50% decline for the 45-64 age group and a 45% reduction for those 65 to 74.

The aging of the entire U.S. population is demonstrated by the decline in the overall death rate. After leveling off in the 1960s the death rate has steadily declined in the 1970s and reached an all-time low in 1975 of 8.9 deaths per 1,000 population.

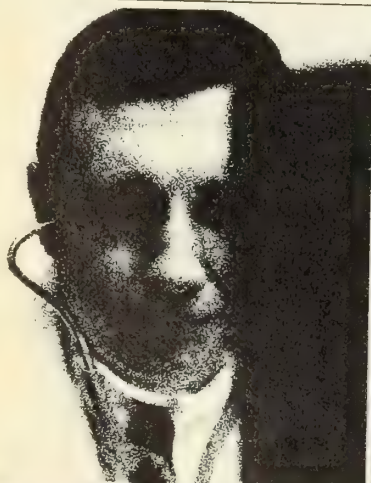
Lung cancer had the biggest jump in death rate, doubling in men and going up four times in women since 1950.

The increase has offset declines in the death rate from cancer of the stomach, rectum, cervix, and uterus.

Infant mortality declined from 29.2 to 16.1 deaths per 1,000 live births, but the United States still ranks 15th in infant mortality.

"The total rate . . . masks persistent differences for major population groups," reports Mrs. Rice. The death rate for black infants is 41% higher than for whites, and for black infants the mortality rate during the first four weeks of life (18.3 per 1,000 live births) exceeds the death rate of white infants during their entire first year of life (14.2).

Mrs. Rice attributes this to the high birth rate among black teenagers with the attendant lack of adequate prenatal care. ◀



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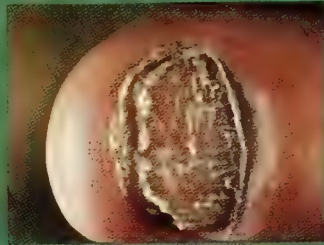
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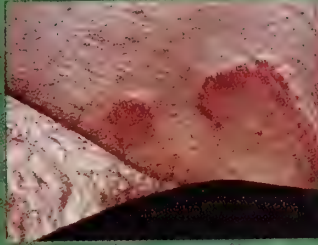
When Griseofulvin is indicated...



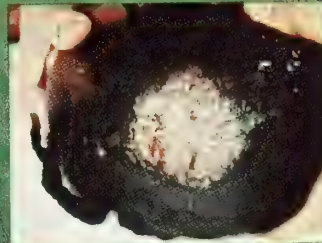
TINEA PEDIS*



TINEA UNGUIUM*



TINEA CRURIS*



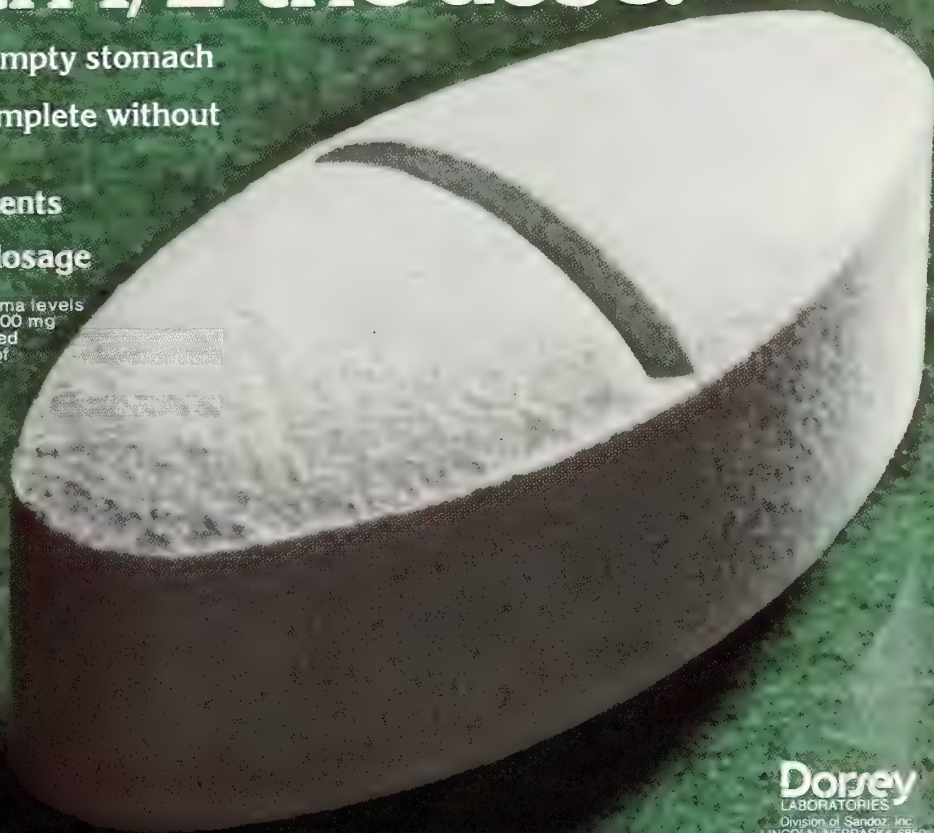
TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG[®] (griseofulvin ultramicrosize) Tablets 125 mg **offers effective therapy with 1/2 the dose.[†]**

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

[†]250 mg of Gris-PEG[®] provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.



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Gris-PEG®

(griseofulvin ultramicrosize) Tablets

125 mg

The ½ dose griseofulvin.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsize griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitale
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleinii
Microsporum audouinii
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following:

Bacterial infections
 Candidiasis (Moniliasis)
 Histoplasmosis
 Actinomycosis
 Sporotrichosis
 Chromoblastomycosis
 Coccidioidomycosis
 North American Blastomycosis
 Cryptococcosis (Torulosis)
Tinea versicolor
 Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatoma in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSEAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6

weeks, *tinea corporis*, 2 to 4 weeks, *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months, toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsize), USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily

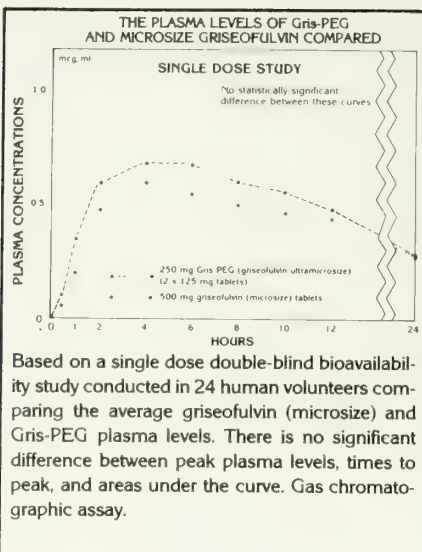
Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

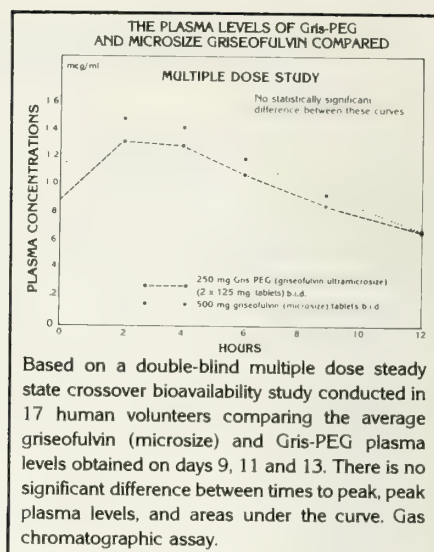
Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsize griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.



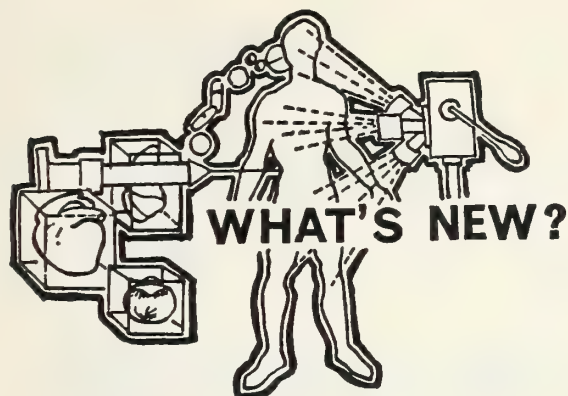
Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

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Wyeth Laboratories announces the availability of Unipen® (sodium nafcillin) as the monohydrate, and Omnipen®-N (ampicillin sodium, in Piggyback Units for convenient, economical intravenous therapy.

Searle announces the introduction of Norpace (disopyramide phosphate), a new drug for the treatment of specific cardiac arrhythmias. Canada has accepted the drug for clinical use and the U.S. FDA is studying the agent. It has been found to be effective in treating ventricular tachycardia.

The UNITED Division of Howmedica has a series of diagram rubber-stamps which produce finely etched anatomical diagrams. There are two sizes of the 250 diagrams of anatomical parts and organs of the body. They will reproduce the diagrams on any type of paper which will accept ink.

Schering is introducing Diprosone Lotion 0.05% (betamethasone dipropionate). It is a new product recommended for relief of inflammatory manifestations or corticosteroid responsive dermatoses. As a lotion it provides a convenient method of application to scalp and other hairy regions.

Mead Johnson has an agreement with Continental Pharma, a Belgian firm, to market Suloctidil in the U.S. Suloctidil is a vasoactive drug effective for both peripheral vascular and cerebral vascular disease states. European experience demonstrates that the drug will increase the walking distance of patients suffering from impaired peripheral circulation. Studies to confirm these findings by research in the U.S. will begin immediately.

Riker Laboratories has been awarded first place in packaging for its BUF™ skin care products. The National Wholesale Druggists' Association 1976 Diana Award was won by the same product in 1975. The winning entry was the BUF™ Kit for Acne which contains a BUF-PUF® Nonmedicated Cleansing Sponge and a BUF™ Cleansing Bar.

Kendall announces a new T.E.D. full leg style anti-embolism stocking. Eight sizes are available. Ninety-

eight percent of patients can be correctly fitted. A patented side panel and waistband hold the stockings comfortably in place.

Ames announces new, longer handles on two multiple reagent strips for urinalysis. The new strips measure 4" for convenience and easier handling. Only the handle is longer—the reagent test area is unchanged. The bottle is 5" high. Prices are the same.

Searle Laboratories has received approval from the FDA which extends the safety and effectiveness claim for its intrauterine copper contraceptive to three years—up from two years.

Doubleday has released "Is There Life After Group?" a paperback which advises on how to select, survive, and expand your encounter group experiences. Encounter weekends, week-long Esalen experiences, classic T-groups, sensitivity training, growth-oriented workshops, consciousness-raising groups and marriage encounter are examples. Written by Lester Libo, professor of psychiatry at the University of New Mexico. It has been recommended for reading by those who do not expect to indulge in encounter group experiences. 148 pages, \$1.95.

Schering announces Optimime tablets, the first new prescription antihistamine product introduced in the U.S. in 16 years. Optimime is a brand of azatadine maleate. It is effective in low dosage and is long-acting.

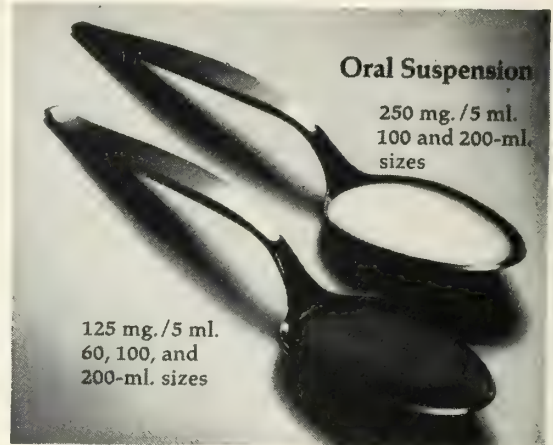
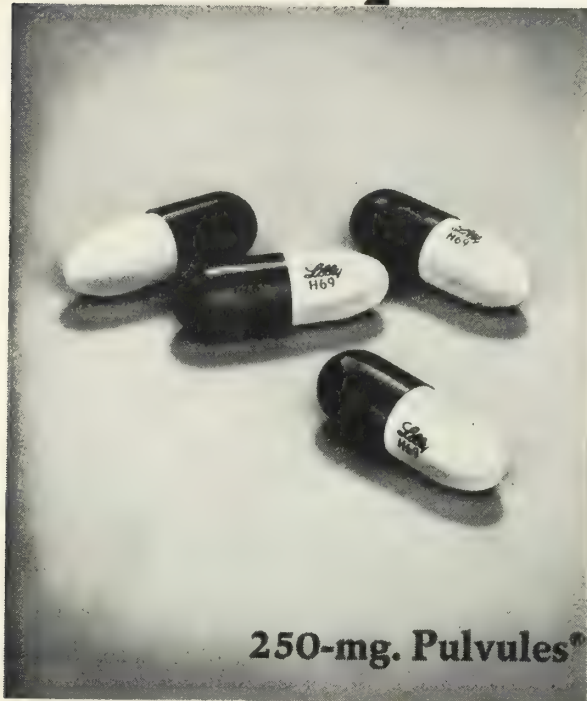
Fulvicin P/G, an ultra-microsized form of griseofulvin, antifungal antibiotic, was introduced recently by Schering. It is indicated for treatment of superficial fungal infections, including ringworm of the hair, body, feet and nails, tinea capitis, tinea barbae, tinea corporis, tinea cruris, tinea pedis and onychomycosis due to specific types of fungi.

Upjohn has announced that its new agent, Colestid, has been approved by the FDA. Colestid (colestipol hydrochloride) is used in conjunction with diet therapy for patients with high cholesterol levels. It will be available about July 1, 1977.

The ARGYLE® SALEM SUMP® tube from Sherwood Medical has been redesigned to offer improved venting. The tube has a double lumen which practically eliminates occlusion of the eyes by tissue. It may be irrigated thru either lumen. An x-ray opaque SENTINEL LINE permits exact positioning of tube and drainage eyes.

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Syphilis Serology Simplified

ARTHUR C. JAY, M.D.
Muncie

ALTHOUGH several articles are published each year on various aspects of the diagnosis and treatment of syphilis, there has been relatively little information on the serological tests for syphilis and their interpretation. This interpretation is a constant source of confusion and consternation to the clinician who has to decide on therapy for the patient who does not have a positive history or physical findings. The following material is presented in outline form and according to the sequence of the natural history of the disease. It is an attempt to untangle the cobweb of results that one faces when the serological report is reviewed.

1. **VDRL NON-REACTIVE:** It is reported as non-reactive.
2. **VDRL WEAKLY REACTIVE:** It is diluted to see if there is a prozone reaction.
 - a. If it is still weakly reactive, it is reported as weakly reactive—an FTA-ABS should be done. (See Section 3.)
 - b. If it is reactive, it is reported as reactive—a VDRL titer and FTA-ABS test should be done. (See Section 3.)
3. a. **VDRL WEAKLY REACTIVE AND FTA-ABS NEGATIVE:** The VDRL is probably an acute or chronic biological false positive result. The VDRL should be repeated at monthly intervals to determine whether it is an acute or a chronic biological false positive result.

By definition:

1. **Acute**—the VDRL is positive less than 6 months.
2. **Chronic**—the VDRL is positive more than 6 months—look for autoimmune diseases and collagen diseases.
- b. **VDRL WEAKLY REACTIVE AND FTA-ABS POSITIVE:** This could be early primary, early or late latent, late syphilis, including neurosyphilis or treated syphilis. These patients may have this serological reaction due to:
 1. A very early disease process which does need therapy.
 2. A treated primary or secondary syphilitic who is responding to therapy, in which no therapy may be indicated.
 3. Early latent, late latent, syphilis or neurosyphilis, all of which would need appropriate therapy.
Repeat the VDRL and re-evaluate the clinical history to differentiate the above.
4. **VDRL REACTIVE:** It is reported as reactive. A *VDRL Titer* and the *FTA-ABS* should be done.
 - a. If the FTA-ABS test is negative, check for an acute or chronic biological false positive.
 - b. If the FTA-ABS test is positive, check the VDRL titer. If it is positive, rising, and

shows at least a twofold rise in dilution (e.g., 1:4 to 1:16), the disease would be considered active or a relapse may have occurred in a patient who had been previously treated. The patient needs therapy with proper follow-up. A one tube dilution change in titer is not significant and falls within the range of laboratory variation.

5. The *darkfield* examination may be positive in primary syphilis or in the macular papular lesions of secondary syphilis. If positive, it may be diagnostic of syphilis and can be correlated with the history and serological tests. The darkfield may be positive before the VDRL in primary syphilis. A negative darkfield does *not* rule out active syphilis. The history and STS tests are necessary.
 - a. The darkfield may be done by the use of classic technic with a wet mount, or it may be done in the office and then allowed to air dry. This slide may then be sent to the appropriate laboratory for a direct fluorescent treponemal test. The latter test should facilitate the procedure being done in the office at the time the patient is originally seen.
6. **PRE-NATAL AND CONGENITAL SYPHILIS:** A syphilitic mother should be treated, and monthly quantitative STS tests should be done after delivery

for six months to a year as follow-up. (See under follow-up.)

a. The mother and baby should have a VDRL and VDRL titer to check for congenital syphilis.

b. The level of antibody can be positive in the neonate in higher titer than in the mother only if there is a congenital syphilitic infection. It should be at least fourfold or higher than the mother.

c. If the antibody is passively transferred, a 30-32 day half-life of the antibody will give a negative STS in the infant in 3-4 months. Do serial quantitative VDRLs every two weeks for 3 months to check the serological response.

d. A negative STS in the neonate does not rule out prenatal syphilis. The antibody may be in the process of developing.

7. **NEUROSYPHILIS:** It is recommended that a spinal fluid VDRL be done:

a. At the end of one year following therapy of primary syphilis or secondary syphilis.

b. When the individual has been treated with oral antibiotics.

c. Where there is any question of early latent, late latent or late syphilis.

d. To rule out the possibility of neurosyphilis or if there are signs or symptoms consistent with neurosyphilis.

False positive cerebral spinal fluid VDRLs are rare in contrast to serum VDRLs. Therefore, a positive VDRL in the spinal fluid virtually indicates past or present neurosyphilis. The titer of the STS may diminish with therapy but may remain positive for years.

SUMMARY

a. The VDRL test is a screening test. It will become positive in 10-90 days following infection and may remain positive.

It may begin declining after six months to two years, or it may disappear entirely as in late syphilis after four years. It may wax and wane as a non-reactive, weakly reactive, or reactive result late in the disease or after therapy. It may revert to negative after treatment of primary or secondary syphilis. (See under follow-up.)

b. The FTA-ABS test is a treponemal test and is considered definitive virtually 99% of the time. It becomes positive earlier and will remain so for life—even if adequate therapy was given. It means that the patient either has or had the disease, and it does not indicate activity of the disease. Therefore, it *cannot be used* for follow-up. False positives are extremely rare. They may be secondary to collagen diseases (i.e. lupus erythematosus).

FOLLOW-UP

a. **Primary or Secondary Syphilis:**

Persons treated for primary or secondary syphilis should be followed-up with a quantitative VDRL at 1-, 3-, 6-, and 12-month intervals after treatment. If after therapy of primary or secondary syphilis:

1. The infectious lesions do not heal or if they reappear,

2. The quantitative VDRL does not decrease in titer,

3. The quantitative VDRL shows a rise in titer of at least two dilutions, the disease may yet be active, or a relapse may have occurred, and re-treatment is indicated.

In primary syphilis, the VDRL should decline and possibly become non-reactive entirely at six months. Most patients will be negative one year after treatment; 75% of the patients adequately treated for secondary syphilis will exhibit a non-reactive VDRL

in two years. Patients who have been treated for primary or secondary syphilis can be discharged from follow-up one year after the non-treponemal tests are negative, or if there has been at least a fourfold drop in titer which remains persistent and stable. A spinal fluid VDRL and cell count should be performed on any patient treated for primary or secondary syphilis if the serum VDRL remains reactive or has failed to demonstrate at least a fourfold decrease to a fixed low-titer at the end of a year. Also, a spinal fluid VDRL and cell count should be done at the time of discharge on all patients treated with oral alternative antibiotics.

b. **Late Latent and Late Syphilis:**

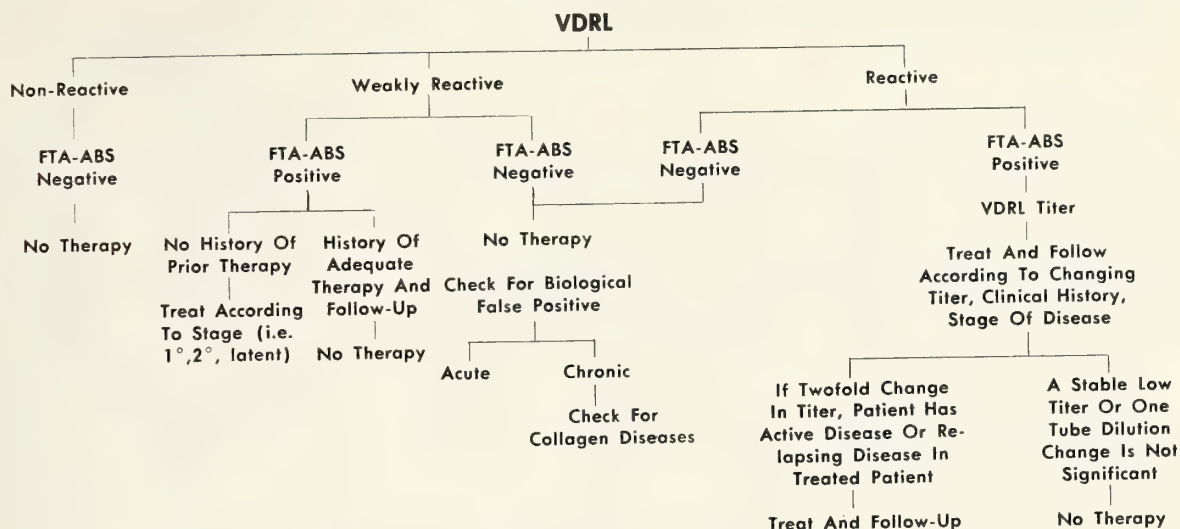
Reversal of the VDRL in primary, secondary, and early latent syphilis will usually occur within six months after treatment. In most of the other stages of syphilis the VDRL will not reverse and will remain positive. The longer the infection is present, the longer it will take for serologic reversal. The STS should be titered. If the titer is relatively constant, further therapy may not be indicated unless the clinical situation demands as follows:

1. In penicillin treated patients, a titered STS should be done every 6-12 months for as long as the patient is sexually active.

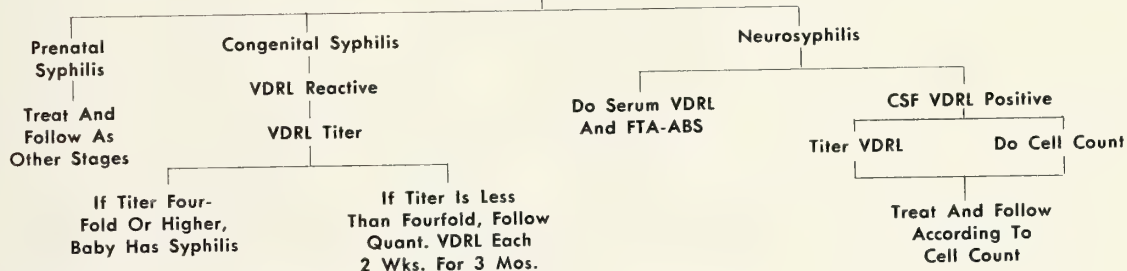
2. In patients treated with alternative antibiotics, a titered STS should be done every six months indefinitely because the therapeutic value of the drugs has not been completely evaluated.

3. Patients with a reactive VDRL in the spinal fluid and who have increased cells and protein in their spinal fluid need repeat spinal taps twice a year for

SYPHILIS SEROLOGY



DIAGNOSIS



1. Do darkfield exam in primary and secondary syphilis.
2. Perform follow-up according to stage of disease as indicated in text.

at least one year after the original examination. The spinal fluid cell count and protein should be within the normal range in one year, but the reactive spinal fluid STS may persist indefinitely.

c. Syphilis in Pregnancy

The follow-up of syphilis during pregnancy should be exactly as in the other types of syphilis, and this depends on the stage of the disease at the time of diagnosis.

d. Neurosyphilis

1. There may be a normal cerebral spinal fluid cell count in active neurosyphilis, but, reportedly, the cerebral spinal fluid cell count still provides the best laboratory indication as to the success or failure of

the therapy of neurosyphilis. The CSF cell count should be less than six lymphocytes per cu/mm. There may be a temporary increase of cells following adequate therapy, and neurosyphilis may be progressive in spite of a normal CSF cell count.

2. The patient should be examined every three to four months during the first year after therapy and every six months during the second year.

This is a condensation of a large amount of literature. Some of the available sources are included in the bibliography for further reading. Once one has reached the decision that the patient does have syphilis and has classified the stage, therapy is fairly rigidly outlined and easy to follow. Since venereal disease is high on the list in fre-

quency among infectious diseases, I believe that it is necessary to know how to diagnose and treat this infection. This information is intended to aid in that effort and to make the serological interpretation of the patient's result easier.

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Ball Memorial Hospital
2401 University Avenue
Muncie 47303

Penicillinase-Producing *Neisseria gonorrhoeae*

PENICILLIN has been the drug of choice against infections with *Neisseria gonorrhoeae* for the past 30 years. In March 1976 an isolate of *N. gonorrhoeae* was cultured from a man in Maryland with urethritis who had failed treatment on appropriate doses of penicillin. This isolate was resistant to penicillin. The isolate produced an enzyme called penicillinase which destroyed penicillin. Although this enzyme has been identified in other bacteria (i.e., *Staph aureus*) which are resistant to penicillin, this was the first time it had been observed in *N. gonorrhoeae*.

Since the first case in March, through November 1976, the CDC has confirmed 35 more cases of infection with penicillinase-producing *N. gonorrhoeae* (PPNG) in 12 different states. This new strain has also been detected in England, Canada, Korea, Japan, Singapore, the Philippines and Australia. Most cases in the United States are related to people who have had sexual contact in the Far East; military personnel account for many of the cases.

The symptoms, signs and complication rate of infection with penicillinase-producing *N. gonor-*

rhoeae so far appear to be no different from those observed with nonpenicillinase-producing strains. Most cases seen in the United States have been uncomplicated infection, although one case of disseminated infection and one case of localized abscess formation (Bartholin gland) have been observed. In England at least one case of PPNG infection associated with pelvic inflammatory disease has been reported.

Penicillin has been shown to be ineffective against this new strain. In 30 of the first 35 cases seen in the United States where penicillin therapy was used initially, it failed to eradicate the infection. In addition, a small number of cases treated with tetracycline, a drug used as an alternative to penicillin in penicillin-allergic patients, also led to an unacceptable failure rate. Most cases in the United States have been cured with spectinomycin, a drug normally used for the few patients who fail initial therapy with penicillin or tetracycline. Although spectinomycin appears to be effective against this new strain, absolute resistance of *N. gonorrhoeae* to spectinomycin has been documented in the past and injudicious use

of this drug could ultimately result in spectinomycin-resistant organisms.

Since we suspect that the number of cases of this new strain in the United States is very low at the present time, the CDC still recommends 4.8 million units of aqueous procaine penicillin G intramuscularly, administered with 1 gram of probenecid orally, as initial treatment of choice for uncomplicated gonorrhea. All patients should receive a follow-up test-of-cure culture 3-7 days after initial therapy. Patients who have a positive test-of-cure culture should be retreated with spectinomycin 2 grams intramuscularly and again be recultured in 3-7 days.

Surveillance for this new strain is being conducted through state health departments. Physicians requiring assistance in screening for PPNG or in case of follow-up and contact referral should contact health department officials.—A recent release from Venereal Disease Control Division, Bureau of State Services, Center for Disease Control, Public Health Service, Department of Health, Education, and Welfare.



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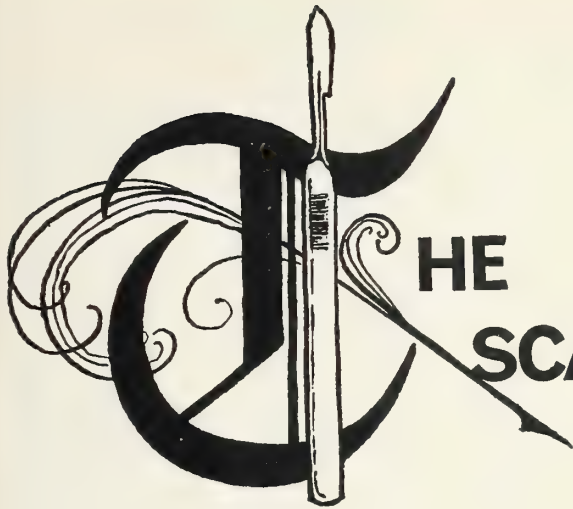
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SCALPEL AND THE PEN

V. Anton Pavlovich Chekov, 1860-1904

RODNEY A. MANNION, M.D.
LaPorte

THE creative spirit seems, in part, to be inborn and to demand a life of its own apart from secondary circumstances of person or environment. This is particularly exemplified in the life of Anton Chekov. This Russian doctor, short story writer and composer of extraordinary stage plays was an unlikely candidate for literary fame in his early years at Taganrog, a small town on the Black Sea in Southern Russia. Although son of a petty and eventually bankrupt shopkeeper and grandson of a freed serf, he had the artistic spark in greatest measure. A large body of precious literature was produced by him in the 24 years from his advent in print in 1880 to his death in 1904. He was a giant rising from the social mediocrity of 19th Century Czarist Russia.

His father was a fanatic for the exterior usages of religion and was a domestic tyrant in an age when many fathers were the same. It is easy, retrospectively, to condemn Chekov's father for his tantrums, child beating and hypocrisy (he instructed the shop girls to weigh their thumbs in the timeless manner of grocery clerks), but, those above him had, in their turn, brutalized him. Pavel Yegorovich fathered six children, the third being Anton,

nicknamed "Antosha."

In addition to his heavy load of homework, Anton was forced at an early age to work in the store, which was usually poorly heated. Chekov remarked in his adult years: "In my childhood . . . I had no childhood." Yet if any of his progenitors had creative talent, it was also this same father, because he was a musician and choral master at the church. Indeed, he was so immersed in these activities, along with endless philosophical discussions with family and acquaintances, that his financial position declined and, eventually, when Anton was 16, Pavel Yegorovich closed the store and repaired with his family to a flat in Moscow. This was a subsistence life among the flotsam and jetsam of that city. Anton, however, stayed alone in Taganrog at the Latin school and made a firm determination to go to the University of Moscow Medical School. He began to show signs of the vital force which would raise him high above his family and friends, even to the pinnacle of literary achievement.

In medical school he composed small pieces for humor magazines under the pseudonym "Antosha Chekhonte." It is paradoxical that one of the greatest writers of somber short stories began with these

funny morsels. But his meager profits allowed him to assist his family and to ultimately supersede his father as family head. He was no rebel but a studious and extremely dutiful provider. His younger sister Marya, called "Masha," remained a spinster and was devoted to him. His brothers drank vodka and fell upon hard times in later years.

After obtaining his degree he practiced in Moscow and was successful in a modest way. At the same time, he augmented his income with a heavy production of short stories. Literature gradually occupied more and more of his attention but he remained a practicing physician. Replying in 1888 to his

Our grandfather was beaten by the landowners, and the lowest functionary could smash his jaw. Our father was beaten by his father, and we by our father. What nerves, what blood we have inherited!

—Letter from Chekov to his brother, 1882.

You possess, dear Sir, a very exceptional talent which . . . has no need to recoil from the most difficult tasks.

—Letter to Chekov from D.W. Grigorovich, 1886.



publisher, Suvorin, who admonished him to give up medicine:

... I feel more contented and more satisfied with myself when I realize that I have two professions and not one. Medicine is my lawful wife and literature my mistress. When I grow weary of one, I spend the night with the other. ... If I did not have my medical work, I could hardly give my leisure and my spare thoughts to literature. ...

He felt that his scientific medical background was an advantage to an author:

It really isn't bad to be a doctor and to understand what you are writing about. The ladies say the description of confinement is true. (In the story called "The Name-Day Party.")

Even when he rented a summer lodge for his family at Babkino in 1885 he did not fail to practice medicine and wrote:

"The sick swarm and plague me here ... in the course of the summer several hundred have come and I've earned the total of one ruble."

These were the "muzhiks" of the area whom he treated gratis. In 1886, after he had gained wide no-

toriety as a writer, he received a letter from the then famous novelist, D. W. Grigorovich, which changed his life:

... It would be a tragedy were you to squander your gifts on literary trifles. I feel the urge to implore you not to do this, but to concentrate on work of genuine artistic merit.

Never again would a story from his pen bear the sobriquet Antosha Chekhonte; from that day on he wrote under his own name, Anton Chekov.

What of the human being behind the name? A picture of him with his family shows a handsome man about six feet in height. He was said to have eyes shading in color from blue to brown and the picture shows an intelligent, almost sardonic, but rather kind expression. He was an agnostic and materialist who feared religious oppression. He inveighed against an author who had disparaged science masquerading as idealism:

Such crusades are incomprehensible to me. To forbid a man the materialistic conception is to forbid him to seek the

truth. Outside matter there is neither experience nor knowledge, and therefore no truth.

Only a few of Chekhov's friends knew him intimately; nevertheless, he was usually surrounded by his large family and numerous acquaintances; he married only three years prior to his death and he himself stated that he lacked "depth of feeling." His struggle up from genteel poverty had sapped him of some of his affective emotions and his stories bear this trait exactly. The great tragedy of Chekhov's life, the cause of much of his pessimism, was his tubercular condition. This was first manifested by hemophthisis shortly after graduation from the university. It gradually resulted in his death.

In later life, after a publisher named Marx bought his entire output and brought out formal bound volumes of his work, Chekhov playfully announced that he had become a "Marxist." In this manner, also, he eschewed politics and activism, saying that "our business is to write and only to write." However, he was not blind to the stultifying effect of the autocracy that was 19th Century Russia and he resigned from the Russian Academy of Sciences when Maxim Gorky, a Communist, was refused election to that society. He was Gorky's good friend and confidant but Chekhov wrote this:

I believe in individuals. ... In my opinion salvation will come from isolated persons scattered all through Russia, whether they be intellectuals or peasants. (Feb. 22, 1899)

He was, nevertheless, suspicious of the motives and sincerity of the intelligentsia and this is defined in such famous stories as "The Black Monk." Again, his lack of political views is expressed in a letter written in October 1889:

I am afraid of those who look for a tendency between the lines, and who are determined to regard me either as a liberal or a conservative. I am not a liberal, not a conservative ... I should like to be a free artist and nothing more ... I hate lying and violence in all their forms. Pharisaism, stupidity and despotism reign not in merchants' houses and prisons alone. I see them in science, in literature, in the younger generation. ...

The Soviet enthusiasm for Chekov has waxed and waned over the years and with some reason, for on the one hand he exposes the bourgeoisie, while on the other he recognizes the despotism inherent in rule by the proletariat.

He was a realist who painted his word pictures with a minimum of strokes and usually relieved the sentiment and pathos with generous amounts of common sense. He wished to show the human condition honestly and to moralize not one "kopecks-worth." Some of the words and metaphors used to define his work are: shaded lights, autumnal tone, lack of heroic proportions, petty, ironic, unfulfillment, frustration, and so on. Yet a translator, Stark Young, says,

He is like a wise, evenly balanced doctor who takes all in his stride. He can portray the human scene without bitterness, harsh theories or sentimental indulgence,

and thus is thought never to be truly depressing. Tolstoy resented his lack of moralizing and Chekov fell out with him on this point saying:

To the devil with the philosophy of the mighty ones of this world! . . . All great sages are as despotic as generals, and as rude as generals, convinced as they are of impunity.

After gaining wide readership, especially among the intellectuals, with stories such as "The Steppe," "A Tedious Tale" (a favorite of Thomas Mann) and "A Doctor's Visit" (in which he originated the phrase "an honorable sleeplessness"), to name three out of a production of more than 600 stories, Chekov first gained a European reputation with his stage plays. Although he had written earlier plays such as "The Bear" and "Ivanov," his first masterpiece was undoubtedly "The Sea Gull," produced in St. Petersburg in 1896. At first a failure, it was played successfully by Stanislavsky at the Moscow Art Theatre in the following year. This has, like his other plays, an immobile story line without any great climax and leaves the audience with unended thoughts. The inter-

est lies in its true characterizations and a rich interaction between the principals. It ends, however, with a tragic suicide.

The themes of his plays are unobtrusive on the surface but have poignant qualities. "The Three Sisters" (1901) concerns the monotonous and loveless life of spinsterhood in the provinces and the first act ends with a pervading sense of ennui. Then a regiment is posted to the town and the three sisters come alive and stop dreaming—gaiety and life reign for a time. The last act shows the soldiers leaving and the lapse of the sisters' lives back to remorseful dreams. It appeals to the viewer today because of the underlying search for the meaning of life.

His two remaining famous plays are "Uncle Vanya" (1899) and "The Cherry Orchard," produced in the year of his death, 1904. The author (just as Oliver Wendell Holmes) had a particular love of trees and had a garden and an orchard everywhere he lived. The action in "The Cherry Orchard" occurs with the sound of the axes cutting the trees in the background while the dissolute and confused former owners gabble impotently on the stage. Frustration is its leitmotiv, as with most of his work.

He married Olga Knipper in 1901. His wife was young and was an actress for the Moscow Art Theatre. She was importunate in her desire to marry him and he relented, although by that time he was more in need of a nurse than a spouse. She never accompanied him on his excursions away from the Moscow winters to Nice or Yalta and was devoted to her own profession of acting. Nevertheless, it is said, she loved him in her fashion and was with him at the end of his lifetime. In the last years he would be unable to go to the theatre and would invite his friend Bunin up to his Moscow apartment and he and Bunin would talk until the small hours. Then Olga would come home, perhaps accompanied by the debonair director Nemirovich-Danchenko, wafting the smell



of perfume and wine, and would order Bunin home.

What could have been if this man was not constantly feverish and weak from his disease? Perhaps his sufferings gave him the very insight which makes for artistic greatness? Chekov has left in his "notebook" some insights into the essence of his art. There are miniature Chekovian plots. One is of special medical interest:

Z. goes to a doctor, who examines him and finds that he is suffering from heart disease. Z. abruptly changes his way of life, takes medicine, can only talk about his disease; the whole town knows that he has heart disease and all the doctors, whom he regularly consults, say that he has heart disease. He does not marry, gives up amateur theatricals, does not drink, and when he walks he does so slowly and hardly breathes. Eleven years later he has to go to Moscow and there he consults a specialist. The latter finds that his heart is perfectly sound. Z. is overjoyed but he can no longer return to a normal life, for he has got accustomed to going to bed early and to walking slowly, and he is bored if he cannot speak of his disease. The only result is that he gets to hate doctors—that is all.

These last words are the key to his plot and make Chekov different from writers such as deMaupassant, who sometimes seems to feel disdain for his characters.

Chekov lived "in the corridor" of death for years with his medical

knowledge of his own disease, but he never let down. He was always to be seen impeccably dressed with fresh linen and a waistcoat. His personal demon was a fear of "peasantness" and he conquered it but at some expense to his personality. His friend Gorky remained an unabashed "muzhik" and the patrician Tolstoy glorified the Russian peasant, much to Chekov's chagrin and disgust, for he was too close to that life in his origins to have illusions.

Again, the "Notebook" provides the final thought for this wonderfully creative literary doctor. It also was a nucleus for a never-to-be composed Chekov story:

Watching from a window as a funeral went by, someone said: "You, you're dead and they're taking you to the cemetery; me, I'm going out to lunch."

But, for all his materialism, he was intensely kind and he served, as he said, his lawful wife, Medicine, and his mistress, Literature, with the greatest zeal all his short life. He was not to be labeled other than as a writer and a doctor. Like Alexander Solzhenitsyn, today, he was a free man despite any and all good reasons to the contrary.

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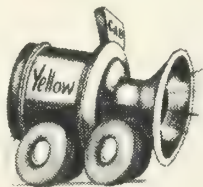


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Neuromuscular Problems in Infancy and Childhood—1

TRADITIONALLY, neuromuscular problems are those which involve the lower motor neuron (anterior horn cell, anterior root and peripheral nerve), the myoneural junction or the muscle itself. If this anatomical classification is then redefined in terms of age of onset and course, a practical clinical approach to differential diagnosis emerges. However, in a significant proportion of cases, finite diagnosis depends on electromyography, nerve conduction time and muscle biopsy. Every effort to establish a firm diagnosis should be made. Then, and only then, can accurate prognosis and genetic counseling be offered the parents.

The complexity of neuromuscular disorders is illustrated by the 12-page "preliminary" classification offered by a Research Group of the World Commission on Neuromuscular Diseases.¹ This includes many conditions not pertinent to infants and children but does offer a useful frame of reference.

Regardless of the primary pathologic site (lower motor neuron, myoneural junction or voluntary muscle), the presenting complaint is motor weakness and, in the infant, hypotonia. More clearly defining the weakness as to age of onset, type of onset, course (acute, chronic, progressive, intermittent) and

duration narrows down the diagnostic possibilities. Further, noting whether the weakness is generalized, localized, distal or proximal is an essential in approaching the problem.

Of special importance in infants is noting if the motor weakness is accompanied by a proportionate decrease in social responses and alertness. If this is the case, a number of cerebral causes of hypotonia must be considered. Cerebral hypotonia is seen in Down's syndrome, hypotonic cerebral palsy with profound cerebral hyposia, congenital malformations of the central nervous system and sepsis, to note the more common conditions.

To return to neuromuscular disorders, the family history is of great importance. In fact, it is not uncommon to examine parents and siblings in order to establish a diagnosis. Further, although the course of a specific neuromuscular disease may vary from family to family, it usually is consistent within a given family.

The first category to be discussed includes those neuromuscular problems due to genetically determined dysfunction of the anterior horn cells. Of these, infantile progressive spinal muscular atrophy (Werdnig-Hoffman) is the one most commonly seen at Riley Hospital. These infants are markedly hypotonic, areflexic and often tremulous. There is usually a notable discrepancy between the motor deficit and the

state of social responsiveness and alertness of the infant. Abdominal respiration with corresponding decrease in intercostal respiration soon leads to flaring of the lower ribcage. All muscles are affected. In one variant there is very early severe bulbar involvement. The disease is present at birth and is inherited as an autosomal recessive trait. Spontaneous mutations do occur.

Classical Werdnig-Hoffman's disease is usually fatal in the first year of life. However, less rapidly progressive forms are occasionally seen. In one family known to Riley Hospital, three siblings were still alive in their early teens. All are severely handicapped.

Less commonly seen is the infantile arthrogryposis multiplex due to anterior horn cell dysplasia. This is essentially non-progressive and is an autosomal recessive trait.

Other genetically determined anterior horn cell amyotrophies beginning in late childhood and early adolescence include the proximal form of progressive spinal atrophy (Kugelberg-Welander). This is an extremely indolent disease causing minimal disability well into adult life. Neurogenic muscle wasting (amyotrophy) due to genetically determined anterior horn cell disease is also seen in the adolescent onset of some of the hereditary ataxia and the rare familial form of juvenile amyotrophic lateral sclerosis.

Dr. Drew is professor of neurology and pediatrics, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

Nongenetic congenital developmental abnormalities of anterior horn cell function of a nonprogressive form include the agenesis of cranial nerve nuclei. The most common of these results in a facial diplegia with external rectus palsy (Moebius syndrome). The congenital absence of muscles (abdominal, pectoral, etc.) may also be included here. Most commonly seen are the amyotrophies associated with the various dysraphisms and dysrachises secondary to failure of spinal column and/or spinal cord midline closure in embryonic development. A readily recognized example of this group is the meningo-myelocele.

If anterior horn cells are destroyed by injury or compression from a variety of neoplastic or infective space-taking masses, the usual picture is neurogenic atrophy at the level of the compression or destruction with pyramidal tract spasticity below that level. This type of clinical situation is most frequently seen in older children.

To complete the roster of neurogenic atrophy (amyotrophy) due to anterior horn cell disease, the rare nonfamilial progressive spinal atrophy of childhood and adolescence must be added. In years past, of course, poliomyelitis was far and away the most common spinal atrophy of children.

Moving anatomically from anterior horn cell to the motor nerve root, the majority of neurogenic atrophies due to dysfunction at this level are associated with meningo-myelocele and related anomalies of vertebra and spinal cord. These are congenital and nonprogressive.

Trauma and compression of nerve roots may occur from tumors and from collapsed vertebrae. X-rays of the spine will frequently make possible the etiologic diagnosis of the motor weakness. Among the neoplastic causes of nerve root compression, neurofibromatosis is by far the most frequently seen in children. This is a dominantly inherited condition. Examination of the par-

ents will usually lead to the diagnosis.

Meningitis and its associated arachnoiditis can result in a radiculopathy. Post-infective polyradiculoneuropathy (Guillain-Barre syndrome) and radiculopathy following immunization will result in neurogenic atrophy.

Peripheral motor nerve pathology as a cause of neurogenic weakness and atrophy covers a very wide range of etiologies which could well be the subject of an entire monograph. The present discussion will be limited to the most frequently encountered types of peripheral neuropathy in children and infants. As in the other forms of neuromuscular disease, weakness, muscle wasting and absent or markedly decreased muscle stretch reflexes are the indications of peripheral motor nerve pathology. However, in the case of peripheral neuropathy (and radiculopathy) and anatomy of peripheral nerves and the muscles innervated by them plays an important role in the differential diagnosis of etiology. Furthermore, an important additional diagnostic aid, nerve conduction times, is available.

The genetically determined neuropathies are quite rare and, with the exception of the neuropathy of Krabbe's infantile cerebral sclerosis and that of metachromatic leucodystrophy, come to medical attention in adolescence or early adult life. Several families with recurrent brachial plexus palsies are known to Riley Hospital. The Indiana type of primary familial amyloidosis occasionally causes mononeuritis multiplex in adolescents. The neuropathic form of arthrogryposis multiplex is another genetically determined infantile neuropathy. Further, they are usually associated with other nervous system abnormalities.

Trauma to the brachial plexus presents at birth as Erb's or Klumpke's paralysis. Other traumatic neuropathies are seen most frequently as the result of direct injury and are primarily limited to later childhood and adolescence. To be noted is the sciatic nerve trauma

secondary to intramuscular injections.

The list of drug, heavy metal and organic substances which induce neuropathy is too long to detail here. Note should be made of the sulfonamides, the cytotoxic agents, mercury (Pink disease), lead, acrylamide and organic chlorine derivatives. A careful history of administration and/or possible exposure is essential in this group of toxic neuropathies.

Another form of toxic neuropathy is that which results from bacterial toxins. These are diphtheria, botulism, tetanus and some forms of dysentery.

Direct infection of peripheral nerves is extremely rare in children and seldom seen in adults. However, indirect, poorly understood neuropathies may occur as part of acute infectious diseases occurring in the pediatric age group. The same comment may be made in regard to postinfective (allergic?) neuropathies.

Peripheral neuropathy is seen in the collagen disorders of childhood, including acute polymyositis and drug-induced systemic lupus erythematosus.

Metabolic neuropathies can be classified as due to specific deficiencies such as folic acid deficiency and cyanocobalamin deficiency. Less specific are the neuropathies associated in a wide variety of nutritional deficiencies.

The peripheral neuropathy of juvenile diabetes continues to be a puzzle as to its specific pathogenesis. Treatment includes good control of the diabetes and supplemental vitamins. The role of vascular insufficiency is not entirely clear.

Neuropathies may occur in both hypothyroidism and hyperthyroidism.

An important cause of peripheral neuropathy in pediatric practice is the leukemic group. Both the disease and its treatment may lead to neuropathy.

Neuromuscular disease due primarily to disorders of neuromuscular transmission at the myoneural junction are much less common and

more limited in number than many of the conditions noted above.

Myasthenia takes two forms in pediatric practice. Transient myasthenia may be seen in the newborn infant with a myasthenic mother. True myasthenia gravis in children is most frequently seen in the preschool group or in early adolescence. It is a rare condition in children. The onset may be subtle with vague generalized weakness, intermittent in character. At other times cranial nerve palsies may be the

presenting complaint. An important differential consideration is the early onset of a pontine glioma.

Toxic myasthenic syndromes include botulism and tick paralysis. In other parts of the world, blowfish and sea snakes produce toxins which block neuromuscular transmission.

Suxamethonium paralysis, genetically determined, anticholinesterase drugs (nerve gases and some agricultural sprays) and, of course, curare compounds result in myo-

neural block of nerve impulse transmission.

The subject of neuromuscular disease due to pathologic dysfunction of the muscle itself is too large to encompass in this brief summary. It will be the subject of a later seminar.

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Guest Editorial

Words from the Speaker

AT the risk of arousing the animosity of our colleagues who faithfully contribute so many hours in our behalf to service on the Board of Trustees, I choose a topic this issue that recently was considered by the Board. This topic is that of national health insurance, or AMA's answer thereto, H.R. 6222, or the "Medicredit Bill." This subject is pertinent to ISMA, inasmuch as our Board firmly instructed our AMA delegates, before the winter session of the AMA convention (in Philadelphia) last November, to oppose any form of national health insurance, including AMA's version. Our delegates faithfully cast all five of our votes to oppose what we considered to be naive legislation authored by our

legislative geniuses at AMA headquarters. But, alas, the final outcome on this emotionally laden issue placed us with a distinct minority in the AMA House of Delegates, by a vote of something like 183 to 57. Hence, not even we can deny that, by a clear consensus, supporting H.R. 6222 is a mandate to the AMA from its constituent societies.

Recently, however, ISMA received a formal request from AMA urging our support of this legislation. This request was discussed and debated by the Board of Trustees at its meeting on April 17th. Using what I consider to be distorted logic, certain trustees spoke favorably toward this request, exposing a blatant duplicity. Their arguments hinged upon such tenuous grounds as: (1) We had fought the battle and had lost; (2) Much has transpired since last November

(what?); and (3) Being a component society of AMA morally obligates us to support each of its policies (subservience?).

This touches directly upon ideological differences that pervade all sociopolitical matters—and medical politics is certainly no exception. This was a very sensitive issue last November, and previous sessions of our own House of Delegates leave no doubt of the prevailing sentiments of Indiana physicians. I have witnessed no attitudinal changes among fellow physicians in my area other than to further castigate the thrust of AMA. While we may have lost the battle in AMA, to infer therefrom that we have a moral obligation to support each of its policies makes as much sense as saying conservative politicians should now support liberal causes simply because the majority are liberal and Jimmy Carter is President. Being friendly adversaries of

fers a sobering check and balance to a political system that otherwise would soar off into oblivion in either direction, depending upon which wing was in power. Furthermore, to whom are we morally obligated or subservient? As I see it, our subservience in ISMA is solely to those whom we represent—the membership of ISMA and no one else! This is the essence of a representative form of government. Somewhere along the way, individuals have been deceived into supporting a perversion of this system, by reversing the order of allegiance, which is tantamount to totalitarianism. The only area in which we should all be in agreement, in a free society, is our right to disagree. Isn't it ironic that it is the liberal who so often is programmed to accuse the conservative of advocating dictatorship?

At any rate, the final outcome on the issue of ISMA support of H.R. 6222 (Medicredit), at the April 17th meeting, was a slightly more acceptable verbiage that, in essence, states: ISMA is still opposed to any form of NHI, but should we be forced to choose, we would prefer (not support) the AMA bill. This is, at least, somewhat in concert with prevailing sentiments of Indiana physicians. The Board of Trustees voted 10 to 4 in favor of this policy. The 4 opposing votes were held out for outright refusal of AMA's request.

I discuss this sensitive subject with some degree of fear and trepidation. For certainly, ISMA has its share of skeptics and dissidents. The very last thing I want to see in ISMA is an exodus of membership. It would grieve me severely if I felt that I would be in any way responsible for giving impetus to such a loss. Indeed, I urge each physician in Indiana to give his support to ISMA and AMA. If you are unhappy with the policies of these organizations, then get into the battle, and become involved with and aware of how you are being represented. I can assure you that our AMA delegation fought a valiant, though losing, battle

last November, and we can be proud of them. I can't say the same for our colleagues in neighboring states where grassroots conservatism is known to prevail. Remember, ISMA is *your* organization and, by virtue of its tenure and stature alone, and as a component society of AMA, its policies will carry far more clout with Congress and with the general public than any other organization, regardless of the latter's objectives and motivations.

The ISMA convention this year will be held October 23-26. I would be very pleased if the general membership would cause a little chaos by exceeding the capacities of the reference committee meeting rooms. In the meantime, attend your county society and district meetings, formulate resolutions, and inform your delegate(s) and trustee(s) just how you feel. Then followup and inform yourself about just how well you feel you are being represented. [This latter step of political awareness is one that is sorely neglected by the majority of citizens, and well educated physicians are equally negligent in this area.] This, after all, is the truly American way that Patrick Henry and others intended for us to preserve our freedom.

LLOYD L. HILL, M.D.
Speaker, House of Delegates,
Indiana State
Medical Association
302 No. Duke St.
Peru 46970

Editorial Notes . . .

"Health News Report," F.J.L. Blasingame, M.D., editor, reports that Aetna Life & Casualty will do a one-year test program for its 10,000 Hartford employees by coverage of a second opinion in regard to surgical operations. The second opinion, if opposite to the first, is not mandatory so far as the company is concerned—the patient makes the decision. Travelers and Connecticut General are planning the same option.

Government regulation of genetic research is inevitable. Or, it should be. Politicians and scientists are coming to an agreement in principle and are ready to outline the specifics. Controls for all recombinant DNA (deoxyribonucleic acid) research are on the way. Creating a new bacterium to which no human has any immunity could be as disastrous as measles in the Fiji Islands. Or worse. Guidelines which were issued last year by the NIH have been well accepted by researchers and will probably be the basis for legislation.

Despite massive efforts toward industrial safety, the health of a worker and measures for his protection are still threatened by a great number of unknowns. The Stanford Research Institute reports that there are 20,000 chemicals in common use in industry and about 1,000 new ones appear annually. Only 6,000 of this chemical array have been tested on animals. Workers may encounter several possibly toxic substances every day. Another worrisome element is one which is also shared by those who conduct clinical trials on drugs. Some toxic chemicals such as asbestos are innocuous in laboratory animals but not in humans.

The Center for Disease Control is conducting clinical research on the efficacy of trimethoprim-sulfamethoxazole — Septra or Bactrim — against penicillin-resistant gonorrhea. Trials of therapy will be in the Far East, where the infection is much more common. CDC hopes to have answers by June or July.

"Health Politics," a term sometimes uttered in jest, like "Medical Politics," has apparently been reconditioned for polite society. *Journal of Health Politics, Policy and Law* is the title of a quarterly publication by the Duke University Press.

VA hospital patients, under the new Veterans Omnibus Health Care Act, may be benefited by improvements in their homes, provided at VA expense, if such improvements will make it possible for the hospital-bound veteran to continue proper treatment at home. Those with service-connected disabilities may be reimbursed up to \$2,500 for home improvements, those with nonservice-connected disabilities up to \$600.

The FDA has ruled that New Drug Applications (NDA) submitted after July 7 must be accompanied by evidence of in vivo bioavailability (or meet the criteria set for a waiver). The intent of the regulation is stated "to assure that all drug products that are intended to be used interchangeably . . . are identified and adequately manufactured and tested to assure that they are bioequivalent." The regs are not intended, nor do they require "a physician to prescribe any drug product by its generic name."

Scurvy in the 18th century commonly had a death rate of 50% on long voyages. Captain James Cook is given credit, according to Mobil news release, for putting to practical use, in 1768, dietary information that had been available since 1593 but never used. After Cook demonstrated that scurvy could be prevented it was not until 1795 that the British Navy officially prescribed a preventive diet.

Prescription drugs are not expensive, that is, on a comparative basis. Since 1967 the All Consumer Items index is up 70%; Medical Care up 84%; Food is up 81%; Housing up by 77%; Transportation up 66% and Prescription Drugs 15%. Drugs take up only 8% of the health dollar. Out of a typical \$1,000 hospital bill only \$30 is for the purchase of drugs. Another \$25 to \$30 is spent on control and distribution of drugs.

There are approximately 320,000 veterans rated by the VA at between 50% and 79% disability. A new law authorizes outpatient care for treatment of any medical condition to veterans with 50% or more service-connected disability. The dividing point was previously 80%. Each of the 50-79 group will receive a letter notifying of new eligibility.

Doctors' fees go up like everything else. The rise is exaggerated by many commentators. Some say twice as fast, which is not so. The Consumers Price Index (CPI) for all items in September 1976 was 172.6—the CPI for M.D. fees was 192.2. This is, of course, a little higher but not twice as high. There is no CPI for the cost of conducting a medical practice. If there were, it is extremely likely that medical fees are and have been below this index. Side Note: The CPI for the maximum Social Security tax is now 332.4. All the above indices were 100 in 1967.

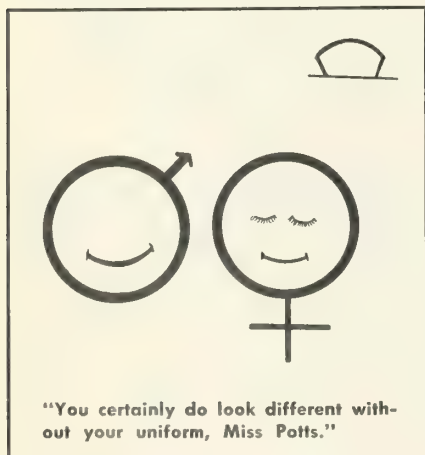
Statistics may be dull at times but at other times may be very interesting. For instance, the pharmaceutical industry in Indiana in 1975 is the subject of a report from the I.U. School of Business, with impressive stats. Thirty one thousand one hundred employees. Total payroll was \$421 million. Tax payments totaled \$241,216,000. Total sales came to \$2.6 billion. Indiana is one of the nation's leading producers of pharmaceuticals; the value added item was between 11% and 12% of the

U.S. total with a rank of fourth among all states. Indiana drug makers invested \$155 million in research in 1975. Totals are for all businesses engaged in manufacture, distribution and dispensing.

With illegitimate births on the increase and in some locations exceeding the number of legitimate births, tests for paternity are more popular. They are also more numerous and more diagnostic. There are more than 60 different blood tests which may be applied. Although no tests will identify the father with complete certainty, it is possible to rule out the accused in more than 90% of cases.

Congress has a bill, the DNA Research Act, which provides rules for all recombinant DNA research and provides guidelines for determining responsibility for untoward side effects, if any. All such research is subject to license by HEW and will be conducted under NIH rules, and followed closely by inspectors. Even with all safeguards possible the research is bound to uncover some completely unpredictable forms of life, any one of which may be as deadly as measles was in the Fiji Islands.

There is universal agreement that vitamins and trace minerals are essential to health. Optimal levels of intake have been determined and announced for most of these micronutrients. Beyond this there is a surprising area of noninformation. Serious degrees of deficiency syndromes are easily recognized but there is so little known about the metabolic disorders that are the result of minor deficiencies as to make the "recommended daily allowance" suspect. Minor deficiency states are, admittedly, difficult to determine clinically. The American Chemical Society, this year, devotes a special symposium to "Micronutrient Needs and Marginal Deficiencies." The program was organized by the Nutrition Affairs Department of Miles Laboratories and will include scientists from many disciplines. ◀



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I N G I S

A S P R E C I O U S

A S S I G H T H A V E

Y O U H A D Y O U R H E A R I N G

T E S T E D L A T E L Y A S I M P L Y

C O M F O R T A B L E H E A R I N G

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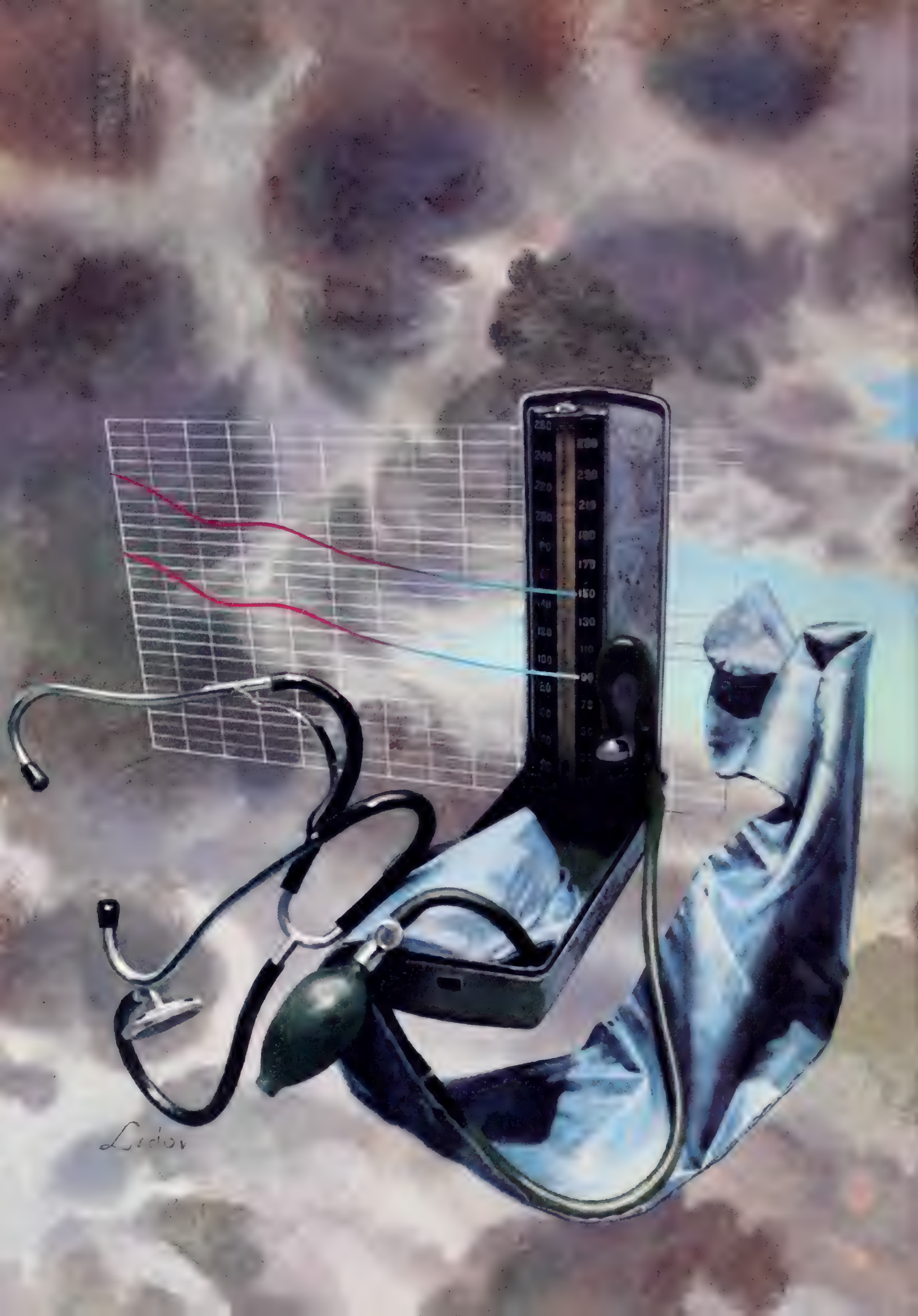
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age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth,

hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References:

1. Dornfeld L, Kane R: Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* 18: 527-533, 1975
2. Data on file, Medical Department, Pennwalt Prescription Products

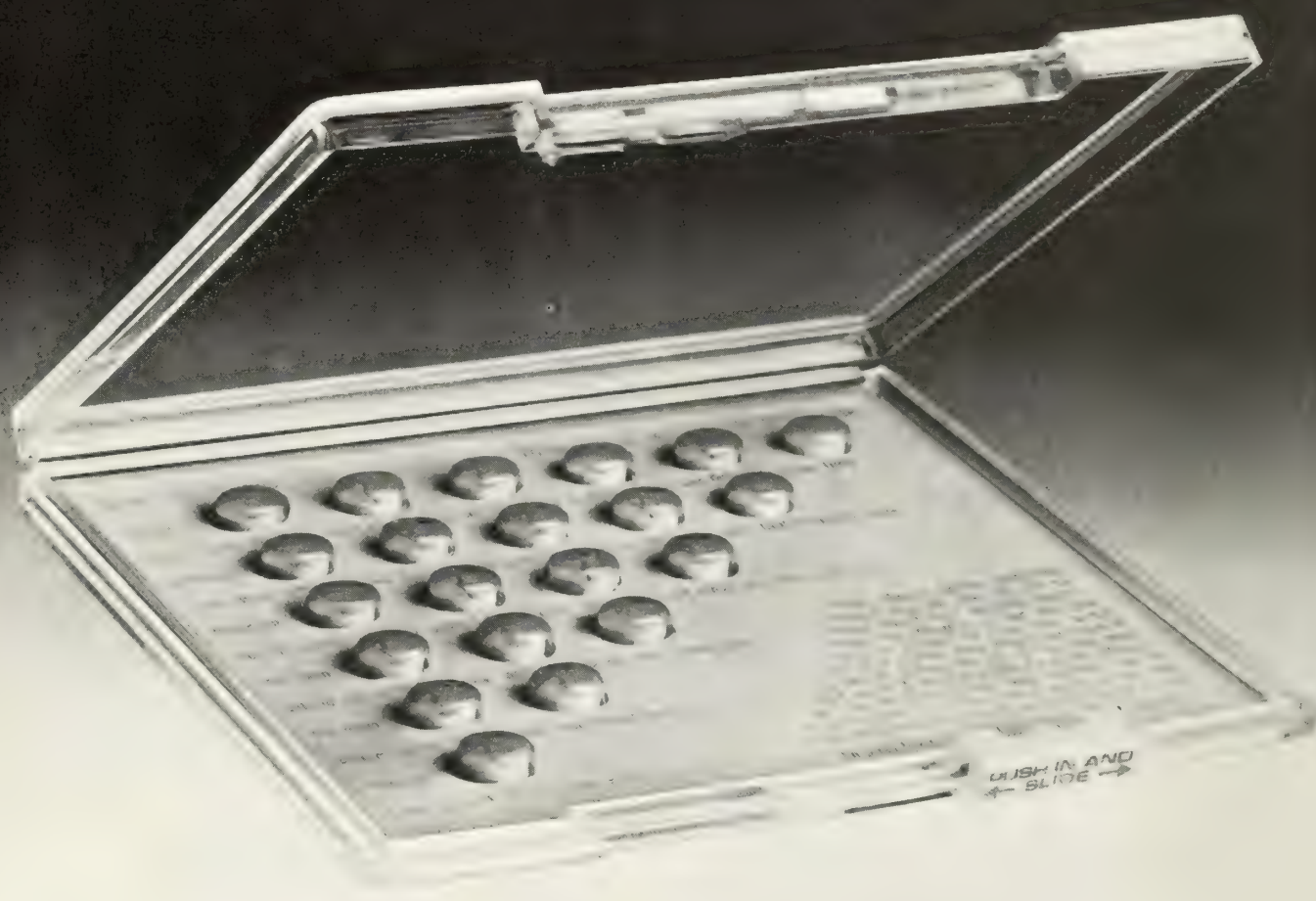
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Medical Directors Required For Skilled Nursing Facilities

ALBERT M. DONATO, M.D.
Indianapolis

IN January 1976 it became mandatory for skilled nursing facilities to incorporate in their staff structure a "medical director," if they wished to participate in the Medicare and Medicaid programs. Aims and hopes of HEW are directed toward improved patient care with the goal of maintaining such care as the best in the world.

The medical director may be a physician licensed under state laws to practice osteopathy or medicine, to serve full time or part time, as determined by appropriate needs of the patients and facility. He may be selected for single or multiple facilities. Arrangements can be made with a single physician, with a group of physicians, local medical society, hospital staff or any similar arrangements. It is understood that any arrangement does not restrict services of the private practitioner to his personal patients. This creates a dual capacity, but should not interfere with effectiveness.

The direction of all skilled nursing facilities is implemented by policy procedures created by nursing staff,

administrative personnel and governing bodies. These policies must be supervised and reviewed by the medical director.

Coordination between nursing director, administrators, owners and attending physicians in general formulates the duties of the physician. To be more specific, the physician's relationship with staff is one of liaison. This means communication, dialogue, consultation, contact and the added flow of information which will benefit patient care, yet by all means the physician/patient relationship must be maintained.

Additional duties would consist of attending meetings of the Health and Safety Committee, Pharmacy Committee, Infection Control Committee, reviewing reports of incidents and accidents, overseeing the health status of the staff, development of emergency patient resident policies, observance of dietary services and facilities, occasional counseling of relatives and supervision of Utilization Review Committee meetings. These may not be all the duties, but certainly they are the most important.

Compensation must be considered on the basis of number of hours to give adequate supervision, the pre-

vailing rate in the local area, and expenses must be considered. The full-time director with no patient care is an exception. Liability coverage depends upon the agreement between the physician and the facility. It is best, though, to consult both the physician's and the facility's insurance carriers to assure that adequate coverage is obtained. There could be many different agreements between the physician or physician groups and the facility and both insurance carriers must be in agreement as to coverage.

The preceding discussion is intended to present an introduction to the medical direction in the skilled nursing home. Your state association is endeavoring to keep abreast of developments and is most willing to supply needed information upon request.

It is anticipated that a Section for Medical Directors of Skilled Nursing Homes will be developed eventually as a part of the ISMA section structure, if there is enough interest. Important bulletins could be circulated periodically to the section members. The mandate is here to stay and we should cooperate to make it work. ◀

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TAX TIPS

by LAWRENCE A. JEGEN, III

Mr. Jegen is a professor of law at Indiana University Indianapolis Law School, specializing in taxation, business associations and estate planning. Professor Jegen urges the reader to consult the reader's lawyer before applying the data in this article to a particular fact situation.

This article continues the discussion of the present gift taxation rules, and continues by presenting examples of computations under the present law. In my April 1977 article, examples were presented which illustrated that a donor's base gift tax marital deduction of \$100,000 is not reduced by the value of gifts which are excluded by the donor's annual \$3,000 exclusions for gifts of present interests. In this article, I shall present computations which illustrate the gift tax computations for gifts which have a total value in excess of \$100,000, but which have a total value of less than \$200,000. In so doing, I shall illustrate that a donor's second \$100,000 bracket is also not reduced by such annual \$3,000 exclusions.

Example Two

Assume that during the first quarter of 1977, H gave \$103,000 of cash to H's spouse, W. Under the new law, H's gift tax marital deduction would be \$100,000. Thus, H would have no taxable gifts for the first quarter of 1977.

Total gifts	\$103,000
Exclusion	— 3,000
Gross gifts	\$100,000
Marital deduction	— 100,000
Taxable gifts	\$ -0-

Applying the same analysis which was presented in Example One of my April 1977 article, H would (initially) be entitled to a marital deduction of \$103,000 under section 2523(a) (1). However, section 2523(a) (2) (A) limits the marital deduction to \$100,000, which limitation is clearly met.

As to the question of whether H's gifts have entered into the second \$100,000 bracket, this ques-

tion is more difficult to answer, based upon the trick wording of the law. That is, to be more specific, the questions is: Does any part of H's \$103,000 gift reduce the second \$100,000 bracket of gifts—the \$100,000 bracket of gifts, which, theoretically, are taxable in full to H?

Perhaps this type of question can be raised more clearly by assuming that H had made gifts of cash to H's spouse in the amount of \$3,000 per year for 66 years (\$198,000 in all) and a gift of \$4,000 in the 67th year, so that H had given a total of \$202,000 to H's spouse by the end of the 67th year. Thus, again, the question is raised as to the amount of H's first and second \$100,000 brackets which H has absorbed by making these annual gifts of \$3,000. Or, to put the question still another way, what is the amount of H's taxable gifts in the 68th year?

Obviously, in each of the 68 years H would be entitled to an annual exclusion of \$3,000. Thus, during each of the first 67 years H would have no gross gifts, because H would exclude the entire amount which H gave. Then, in the 68th year, H again would be entitled to the \$3,000 exclusion, leaving a gross gift of \$1,000.

Also, in the 68th year, H would also be entitled to a gift tax marital deduction (as determined under section 2523), and section 2523 (a) (1) initially states that H's marital deduction is the entire value of H's gift, namely, \$4,000.

However, section 2523(a) (2) (A) provides that H's gift tax marital deduction for the current calendar quarter may not exceed the amount of \$100,000 reduced by any marital deductions which were allowed under section 2523 for a prior quarter.

Now, under my interpretation of the new law, since H would never have been allowed a gift tax marital deduction, under section 2523 in the past, H would not have used any of H's first (base) \$100,000. Nor, in my opinion, would H have eroded any of H's second \$100,-

000 bracket. Thus, H would be entitled to a gift tax marital deduction of \$1,000 for the 68th year, and H would still have \$99,000 of H's first \$100,000 base remaining, and H would not have entered H's second \$100,000 bracket.

Applying my interpretation to the case in which H gave a lump-sum gift of \$103,000 to H's spouse, H would be considered to have used all of H's base marital deduction of \$100,000, and H would not have entered H's second \$100,000 bracket.

The next example which I wish to consider is an example which illustrates the computation of taxable gifts in the case where the donor makes gifts to the donor's spouse (now or later) in excess of the \$100,000 gift tax marital deduction base (specifically, in excess of \$103,000) but under \$200,000. The main purpose of this example is to demonstrate that a donor is entitled to a gift tax marital deduction for the first \$100,000 of the donor's gross gifts to the donor's spouse, but then, the donor may be taxable on the gross gifts which the donor makes to the donor's spouse in excess of \$100,000 of gross gifts to the donor's spouse.

Example Three

Assume that during the first quarter of 1977, H gave \$163,000 of cash to H's spouse, W. In this case, H would have taxable gifts of \$60,000 for the first quarter of 1977.

Total gifts	\$163,000
Exclusion	— 3,000
Gross gifts	\$160,000
Marital deduction	— 100,000
Taxable gifts	\$ 60,000

Again, applying the above analysis, H would (initially) be entitled to a marital deduction of \$163,000 under section 2523(a) (1). However, section 2523(a) (2) (A) limits the marital deduction to \$100,000, which limitation is clearly met. Then, section 2523(a) (2) (B) provides that H is entitled to an additional marital deduction in

the amount of 50% of the lesser of:

1. The amount which would be allowable as a deduction for the current calendar quarter under section 2523(a) (1) without considering any of the limitations under section 2523 (a) (2); and,
2. The amount, if any, by which the total of certain other amounts exceed \$200,000. The total of these other amounts consists of the amounts which would be allowable, under section 2523 (a) (1), as marital deductions for the current calendar quarter and for the preceding calendar quarters which begin after Dec. 31, 1976.

Applying these two alternative tests to the above facts (in which H already is entitled to a minimum marital deduction of \$100,000) will yield no additional marital deduction.

The amount which would be allowable as a deduction under section 2523(a) (1) without considering the section 2523(a) (2) limitations is \$163,000 (ignoring the \$3,000 exclusion). Further, the amount by which \$163,000 (plus all amounts allowable as deductions under section 2523(a) (1) for all other quarters after December 31, 1976) exceeds \$200,000 is zero. And, 50% of zero is zero. Thus, until H has given H's spouse more than \$200,000, H will not be entitled to a marital deduction in excess of \$100,000—because until then, the amount under (2), above, will continue to be zero.

Therefore, to repeat earlier statements, after Dec. 31, 1976, each donor is entitled to a \$100,000 marital deduction base, and if the donor's total gross gifts (after Dec. 31, 1976) exceed \$100,000 (but are less than \$200,000), then the donor will not be entitled to any additional marital deduction for such gifts.

The next example which I shall present is one which will illustrate the computation of taxable gifts where the donor makes gifts to the

donor's spouse (now or later) in excess of \$200,000. The main purpose of this example is to demonstrate that after a donor has made gross gifts to the donor's spouse in excess of \$200,000, the donor is entitled to a marital deduction which is in addition to the donor's \$100,000 base marital deduction.

Example Four

Assume that during the first quarter of 1977, H gave \$103,000 of cash to H's spouse, and then, during the first quarter of 1978, H gave another \$103,000 to H's spouse. The computation of H's taxable gifts for 1977 is presented in Example Two, in which it was demonstrated that H was entitled to a \$3,000 exclusion and a \$100,000 marital deduction for 1977. Below is the computation of H's taxable gifts for 1978.

Total gifts	\$103,000
Exclusion	— 3,000
Gross gifts	<u>\$100,000</u>
Marital deduction	— 1,500
Taxable gifts	<u>\$ 98,500</u>

Because H has already used H's \$100,000 gift tax marital deduction base during 1977, section 2523(a) (2) (A) provides that H is no longer entitled to deduct any part of that \$100,000 base. Thus, if H is to be entitled to any additional marital deduction, then the authorization for such additional amount must be found in the provisions of section 2523(a) (2) (B).

At this point, you should reread the second paragraph under Example Three, above, in order to have in mind the provisions of section 2523(a) (2) (B).

As stated above, section 2523(a) (2) (B) provides two alternative tests in order to determine whether H is entitled to any additional marital deduction. The first test, under section 2523(a) (2) (B) (i), requires H to compute the amount which would be an allowable deduction to H for the current calendar quarter under section 2523(a) (1). Ignoring the \$3,000 exclusion, this amount is \$103,000, and, taking the \$3,000 exclusion

into account, this amount is \$100,000. Thus, a question is raised as to whether section 2523(a) (2) (B) (i)—by referring to the amounts which are otherwise deductible under section 2523(a) (1)—contemplates the incorporation of the limitations under section 2524 when the amount under section 2523(a) (1) is determined. Clearly, either interpretation can be made due to the unclear wording of section 2523(a) (2) (B).

Aside from the wording of the statute, it could be argued that section 2523(a) (2) (B) contemplates the application of the limitation of section 2524 on section 2523(a) (1). Obviously, the \$3,000 exclusion is primarily intended to be applicable to gifts by a donor of the donor's own property. And, the marital deduction, in one view, is a recognition of the receipt by the *donee* spouse of property in which the donee already had a one-half interest. Thus, from this view, there is a basic contradiction in allowing a donor to benefit from the \$3,000 exclusion, and then to apply the marital deduction to the value of the property which was so excluded. Nevertheless, this is precisely what the law allowed—prior to the Tax Reform Act of 1976.

In addition to the above comments, it is difficult to conclude, by reading the new statute, that section 2523 does allow the \$3,000 annual exclusion to be applied prior to computing the marital deduction under section 2523(a) (2) (A)—yet does not allow the \$3,000 exclusion to *initially* limit the marital deduction under section 2523(a) (2) (B). Nevertheless, I think that the Internal Revenue Service will interpret section 2523 in this manner.

That is, I believe that the Internal Revenue Service will apply the limitation of section 2524 only as the *final* limitation on the amount of the marital deduction. Thus, under section 2523(a) (2) (A), until a donor has utilized the donor's \$100,000 marital deduction base, the donor will be required to take a marital deduction *only* to the

extent that the value of the gifts to the donor's spouse, for the particular quarter, exceed any available \$3,000 exclusion for that quarter. And, under section 2523(a) (2) (B), after the donor has utilized the donor's \$100,000 marital deduction base, the donor will be entitled to an additional marital deduction under section 2523(a) (2) (B)—after applying the two alternative tests and the 50% limitation therein—only if the value of the gifts to the donor's spouse for the particular quarter exceed any available \$3,000 exclusion for that quarter.

Thus, returning to Example Four, I think that section 2523(a) (2) (B) (i)—the first alternative test—yields the amount of \$103,000.

As to the second alternative test—in section 2523(a) (2) (B) (ii)—the same type of interpretative problem is presented therein. Further, the problem of interpretation is

made even more complex, because section 2523(a) (2) (B) (ii) also requires the reader to determine how Congress intended section 2523(a) (2) (B) (ii) to apply to section 2524, for the purposes of the second alternative test therein, to gifts made by the donor to the donor's spouse in *prior* quarters.

However, in my opinion, the interpretation which I expressed above is applicable here too. Thus, in order to determine the total amount which is described in section 2523(a) (2) (B) (ii)—the second alternative test—the total value of the gifts made to a spouse (during the current calendar quarter and during all prior quarters which are after Dec. 31, 1976) are taken into account to the extent that such gifts qualified for the marital deduction under section 2523(a) (1). And, section 2524 would only be applicable if section 2524 had, in fact, been applicable in a prior

year in order to limit the marital deduction of that prior year. Further, the fact that such gifts were, in fact, taxable (because such gifts fell into the donor's second \$100,000 bracket) is ignored.

Thus, to return again to Example Four, I think that section 2523(a) (2) (B) (ii)—the second alternative test—yields the amount of \$3,000 (\$100,000 plus \$103,000 equals \$203,000; and, \$203,000 minus \$200,000 equals \$3,000).

Then, the 50% limitation is applied to the lower of \$103,000 and \$3,000 (obviously, \$3,000), and, 50% of \$3,000 is \$1,500.

In my next article, I shall finish my discussion of the gift tax marital deduction, and discuss the portions of the new United States Quarterly Gift Tax Return (Form 709, Revised February 1977) which are unlawful interpretations of the new law. You may wish to obtain a copy of the new form in advance of my next article.

OCTOBER						
SUN	MON	TUE	WED	THU	FRI	SAT
<div>SEPTEMBER</div> <div> <div>1 2 3</div> <div>4 5 6 7 8 9 10</div> <div>11 12 13 14 15 16 17</div> <div>18 19 20 21 22 23 24</div> <div>25 26 27 28 29 30</div> </div>	<div>OCTOBER</div> <div> <div>1 2 3 4 5</div> <div>6 7 8 9 10 11 12</div> <div>13 14 15 16 17 18 19</div> <div>20 21 22 23 24 25 26</div> <div>27 28 29 30</div> </div>			<div>LAST QUARTER</div> <div>24h</div>	<div>FIRST QUARTER</div> <div>12h</div>	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
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<div>ISMA 1977 ANNUAL MEETING</div> <div>Hyatt Regency Hotel • Indianapolis</div>						
30	31	NINETEEN SEVENTY-SEVEN				



RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin • 433-76**

**National
Health
Insurance**

**special report
Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
MAC rules**

**Drug
Substitution**

**The Consensus: Documentation
of Health Progress
RESEARCH**

**Mallinckrodt
Mallinckrodt**

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

FUTURE MEETINGS, SEMINARS, COURSES

Sampling for Statistical Analysis Subject of Programs at Georgia Tech

The Georgia Institute of Technology will conduct a three-day program on "Sampling for Statistical Analysis" July 6 to 8, and a one-week program on "Statistical Design and Analysis for Decision Making" July 11 to 15. For details write Mr. George Adams, Georgia Tech, Atlanta, GA, 30332.

Symposium on Polytomography Of Temporal Bone Scheduled

The 17th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otolaryngology at Community Hospital, Indianapolis, on Sept. 17 and 18. This continuing Medical Education activity is acceptable for 12 credit hours in Category 1 for the AMA Physician's Recognition Award (PRA).

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technic of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 20. Fee for the course is \$250.

Inquiries should be directed to: The Wright Institute of Otolaryngology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis, 46219.

Defibrillation Conference at Purdue

The second Purdue Cardiac Defibrillation Conference will be held Sept. 19-21 at West Lafayette.

Sponsors of the conference are the Purdue Biomedical Engineering Center and the Association for the Advancement of Medical Instrumentation. Tuition is \$120. Contact Gary Lee, Continuing Education Division, Purdue University, West Lafayette 47907.

Bladder, Prostate Cancer Conference

The American Cancer Society, Kentucky Division, is conducting a "Conference on Cancer of the Bladder and Prostate" on Nov. 4 and 5 at Stouffer's Inn, Louisville. There is no registration fee. Write George A. Sehlinger, M.D., 2313 Medical Arts Bldg., Louisville 40217.

Clinical Neuro-Otolaryngology Course

The Fourth Continuing Education Course in Clinical Neuro-Otolaryngology will be conducted by the University of Pittsburgh School of Medicine Nov. 17 to 19. Tuition is \$190 for practicing physicians and \$95 for residents. Write Sidney N. Busis, M.D., 1022 Scaife Hall, University of Pittsburgh School of Medicine, Pittsburgh, PA 15261.

Symposium on Fundamental Research

The M. D. Anderson Hospital and Tumor Institute, Houston, Texas, will sponsor its 31st Annual Symposium on Fundamental Research at the Shamrock Hilton Hotel March 1 to 3, 1978. The topic will be "Identification and Mechanisms of Action of Carcinogens." For particulars write Stephen C. Stuyck, M.D., Anderson Hospital, Houston 77030.

Schedule for Upcoming NCME Programs

The Network for Continuing Medical Education announces the following schedule of programs:

May 30-June 12 THE DIAGNOSIS OF HYPERTHYROIDISM: A DECADE OF PROGRESS. This telecourse is co-sponsored for continuing medical education credit by Downstate Medical Center, State University of New York, and qualifies for one hour of Category 1 credit for the Physician's Recognition Award of the AMA. It is also accepted for one-hour of Prescribed credit by the American Association of Family Physicians. AOA members may earn credit in Category 2. Program features Sidney H. Ingbar, M.D., professor of medicine and director of the Thorndike Laboratory, Harvard Medical School and Beth Israel Hospital, Boston.

"PRIMARY BILIARY CIRRHOSIS: MANAGEMENT OF AN ENIGMA," with Fenton Shaffner, M.D., George Baehr Professor of Medicine and Chief, Division of Liver Diseases, Mt. Sinai School of Medicine, New York.

June 13-July 10 "EVALUATING PATIENTS WITH OCCLUSIVE CEREBRAL VASCULAR DISEASE," with Noble J. David, M.D., chief of the neurology service, Miami Veterans Administration Hospital, and Professor of Neurology at the University of Miami, Florida.

"PAPILLOEDEMA Vs. PSEUDOPAPILLOEDEMA: RECOGNITION AND DIAGNOSTIC CONSIDERATIONS," with Richard E. Goldberg, M.D., director, and Larry E. Magargal, M.D. codirector, Retinal Vascular Unit, Wills Eye Hospital, Philadelphia, and the Retina Unit of Holy Redeemer Hospital, Meadowbrook, Pa.

"THE BETA ADRENERGIC THEORY OF ATOPIC DISORDERS," with E. William Rosenberg, M.D., professor of dermatology and associate dean, University of Tennessee College of Medicine, Memphis; and Andor Szentivanyi, professor of pharmacology and internal medicine, and chairman of the Department of Pharmacology, University of South Florida College of Medicine, Tampa.

July 11-Aug. 7 "DRUGS AND THE MENOPAUSE WORKSHOP," with John Moyer, M.D., director of professional and educational affairs, Conemaugh Valley Memorial Hospital, Johnstown, Pa.; Elizabeth Connell, M.D., associate director of health sciences, Rockefeller Foundation, New York City, and consultant to Obstetrics and Gynecology Advisory Committee of FDA; Herbert Kupperman, M.D., director of endocrinology, Lenox Hill Hospital and associate professor of medicine, New York University Medical Center, New York City; Theodore King, M.D., chairman of the Department of Obstetrics and Gynecology, Johns Hopkins Medical School, Baltimore, and chairman of the FDA Obstetrics and Gynecology Advisory Committee. This presentation is part of the American Society for Clinical Pharmacology and Therapeutics' Drug Spotlight program.



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NEWS NOTES

Auerbach Award to Dr. Popplewell

Dr. Arvine G. Popplewell, Indianapolis, received the Murray Auerbach Award at the recent meeting of the American Lung Association in Indianapolis. The award, named for the late executive secretary of the Indiana Tuberculosis Society, is given annually to recognize outstanding service fighting tuberculosis and other lung diseases. Dr. Popplewell serves as treasurer of ISMA.

Malpractice Premiums Reduced

Physicians and Surgeons Liability Insurance Company, Inc. (P&SLI) of Munster has reduced its medical malpractice insurance rates. The decrease in premiums was approved by the Insurance Commissioner of the State of Indiana to become effective May 1, 1977.

The reduction in rates will be 15% for physicians in Classes I, II, and III. The remaining classes will be decreased by 10%.

P&SLI has completed its first year of operation and has found its malpractice claims experience to be better than anticipated. The number of malpractice claims in Indiana has markedly diminished. With the inherent flexibility of a claims made contract, P&SLI felt that a reduction in premium rates was warranted.

"If conditions continue to improve," said President Sidney R. Goldstone, M.D., "our rates will consequently continue to decline."

Booklet for Chemotherapy Patients

"Chemotherapy And You" is the title of an 8-page booklet published by HEW for the instruction of patients concerning the use, potentials, side effects and precautions relating to chemotherapeutic agents. It is designated as DHEW Publication No. (NIH) 76-1136.

Blood Bank Ass'n Opposes Regulation

The American Association of Blood Banks announces that it opposes the proposed FDA regulation that would require all blood and blood components intended for transfusion in the U.S. be labeled as to whether procured from "paid" or from "volunteer" donors. The AABB pointed out that, while the regulation would discourage the use of blood purchased from undesirable high risk sources, it would also discourage the use of blood from very high quality paid donor sources presently providing the safest blood available to some of the most prestigious medical institutions.

Radiation Emergencies Booklet Offered

The National Fire Protection Association sells a new book on "Handling Radiation Emergencies." Not a bad subject for an Emergency Department. Radiation emergencies are rare but, when they occur, they do not leave much time for "looking up" the essential information. The price is \$8.75. Recommended for all Emergency Departments, medical, fire and police. The address is 470 Atlantic Ave., Boston 02210.

Symposium Marks Opening of New Cardiovascular Clinic at Bluffton

A "Symposium on Coronary Disease" was held at the Caylor-Nickel Clinic on February 19 as a part of the opening ceremonies of the new Cardiovascular Laboratory of the Clinic. Ramon J. Villamil, M.D., director of the CV Lab, organized the scientific program.

The program was opened, appropriately enough, by an historical account of the development of coronary angiographics, given by Dr. Mason Sones, one of the pioneers who demonstrated the clinical values of cinematic visualization of the coronary circulation.

The first cardiac catheterization was accomplished in 1929 by an Australian house officer using urological catheters. Study of the heart chambers was carried out in Sweden in the 1940s. Later, around 1957, the closed circuit television screen and image amplifiers were applied to the task of viewing the coronary arteries. By 1965, the six-inch image amplifier and the 35 mm camera produced films of high diagnostic potential.

Dr. Augusto Pichard, of Mt. Sinai Hospital, New York City, described the natural history of coronary artery disease and the indications for coronary angiography. His discussion also touched on the interpretation of angiographic findings and the determination of therapeutic medical and surgical procedures. His conclusions were that, due to the precise diagnosis made possible by angiography, treatments properly applied had effectively controlled symptoms and had lessened the incidence of myocardial infarction and sudden death.

"Surgical Indications and Prognosis of Aorto-Coronary Bypass Grafts" was discussed by Dr. Chalit Chanvechai, of the Methodist Hospital, Peoria, Ill. The discussant's own experience at the Cleveland Clinic from 1970 to 1974 included bypass grafts on 1967 patients with a hospital mortality of 1.88%. Postoperative study of 1650 grafts showed a patency rate of 89.3%, while 92.3% of these patients became asymptomatic after surgery. In addition to relief of angina there has been evidence that longevity is increased, especially in those patients with double or triple grafts.

Harry Davis, Honorary Member, Dies

Harry C. Davis, 71, executive secretary of the St. Joseph County Medical Society from 1940 to 1976, died on April 1. He was an honorary member of ISMA. He was also an honorary member, teacher and advisor to the Indiana Association of Medical Assistants, St. Joseph County Chapter. He was also active in numerous public service organizations.

Dr. Koch Heads Roentgen Society

Dr. Edwin Koch, Muncie, has been elected president of the Indiana Roentgen Society, Chapter of ACR. Other officers are: Dr. William J. Miller, Lafayette, president-elect; Dr. Richard F. Fox, Fort Wayne, secretary; Dr. E. A. Franken, Indianapolis, treasurer; Drs. Theodore Megremis, Bloomington, and Gerald Kurlander, Indianapolis, counsellors, and Drs. Donald Zalack, Michigan City, and Dale Parshall, Elkhart, alternate counsellors.

Clinical Engineering Journal Started

A new "Journal of Clinical Engineering" is being introduced by Quest Publishing. It is a quarterly and will be devoted to such subjects as hospital instrumentation services, technical work in clinical engineering, career opportunities, costs and certification. A single complimentary copy may be obtained by writing Mrs. Charlene Whitney, P.O. Box 4141, Diamond Bar, CA 91765.

Continued

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Continuing Medical Education

Audio Cassettes Available

Audio cassettes are now available for the following presentations made at the Mar. 25-26 Institute on the Child with Learning Disabilities held at the Indiana University School of Medicine:

Speaker	Presentation
Larry Silver, M.D.	The Role of the Child Psychiatrist
Marian DeMyer, M.D.	The Detection of Learning Disabilities and the Evaluation of the Preschool Child
Irene Stephens, Ph.D.	The Evaluation of Normal and Deviant Development of Language
William DeMyer, M.D.	The Neurological Evaluation and the Use of EEG
Eugene Roach, Ph.D., M.D.	Psychological Tests
Sylvia Richardson, M.D.	The Physician's Collaborative Role with Child, Parents, Educators and Psychiatrists
Richard Snider, Ph.D.	The Psychologist's Collaborative Role with Child, Parents, Educators and Physicians
Nicholas Anastasiow, Ph.D.	The Educator's Collaborative Role with Child, Parents, Psychologist and Physician
Panel	Summary Remarks and Discussion of Presentations

The Institute was given under the auspices of the American Academy of Child Psychiatry and the Department of Psychiatry, I.U.S.M.

For information as to obtaining the cassettes write to Audio Archives, Inc., One IBM Plaza, Suite 3302, Chicago 60611.

AMA Award Achieved by 34 Hoosiers

The following Indiana physicians are recent winners of the coveted AMA Physician's Recognition Award:

Amarnath B. Agrawal, Michigan City	George R. Kiracofe, Richmond
Raquel Altuna-Ramirez, Valparaiso	James D. Kubley, Plymouth
Virgil E. Angel, Highland	Hamlin B. Lindsay, Washington
Miguel F. Beruben, East Chicago	Joel L. McGill, Brownstown
Surjeet Kaur Bhango, Richmond	Herbert L. Murillo, Munster
Jose Fernal Bicalho, Merrillville	Arthur L. Norins, Indianapolis
Venustiano H. J. Borromeo, Crown Point	Chris A. Pascuzzi, South Bend
Thomas D. Breitweiser, Madison	John D. Pattison, Marion
James D. Chandler, Kendallville	Michael G. Quinn, Mishawaka
Marion L. Connerley, Terre Haute	John M. Records, Franklin
Charles J. Frahm, East Chicago	H. Jerome Rietman, Evansville
Stephen H. Glassley, Fort Wayne	Merrill W. Rusher, Fort Wayne
Sesinando A. Gonzales, Highland	Harry Silvian, Whiting
Thomas J. Hicks, Fort Wayne	Eduardo V. Sison, Valparaiso
	Max E. Sneary, Avilla
	George V. Teter, Indianapolis
	Dan L. Tritch, Fort Wayne
	Elaine H. Waiss, Munster
	Fred R. Walton, North Vernon
	Rosemary E. K. Weir, Muncie

From THE JOURNAL 50 Years Ago

Well, well! So the governor as well as the attorney-general of Indiana are law-breakers. Both procured whisky to be used as a medicine for members of their families who were desperately ill. Such conduct is prohibited by law and is punishable by fine or imprisonment. Indiana's "bone dry law" absolutely prohibits a physician from either prescribing or giving any alcoholic beverages, no matter how small the quantity nor how urgent the need for such a remedy to save life. The question is, what will Rev. Shoemaker and all other prohibition fanatics do about this flagrant violation of Indiana's laws? The attorney-general has written an open letter to the governor calling upon that official to petition the next Indiana legislature to amend the state prohibition law to conform to the federal law governing the matter, so that alcoholic beverages may be obtained by physicians and prescribed by them for illness under appropriate restrictions.

It doesn't make any difference whether there is a disagreement among medical men as to the therapeutic value of whisky, the fact remains, as pointed out in the resolution passed by the House of Delegates of the AMA at the Washington session, that no lay persons or body of lay persons should dictate to members of the medical profession as to what remedies shall be prescribed as therapeutic agents in the treatment of disease, or in what quantity they shall be prescribed. The principle involved in this discussion is unquestioned by intelligent and rational-minded people. If Congress or a state legislature can dictate as to the amount of alcoholic beverages that a physician may prescribe as a therapeutic agent, then it is but a step farther to dictate as to how much strychnine, digitalis, quinine, or any other therapeutic agent may be used. . . . "The Governor and Attorney General Secure Whisky," editorial, JISMA, June 1927.

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ESTATES

The Auxiliary Reports to ISMA

The Auxiliary: Yesterday, Today, and Tomorrow

We will celebrate our 50th anniversary in October. As we move toward that celebration, it is a time for thoughtful remembrance of our predecessors and a careful assessment of how what we do today will affect doctors' wives and Hoosier communities in years to come.



We have never had to be like the frantic, pioneer doctor's wife. But what we—and our husbands—are today is the result of that time and those courageous people.

Our founders recognized the unselfishness of their husbands and had compassion for them and for those who entrusted their lives to those physicians.

Today, we need the same courage, integrity and resourcefulness that our stalwart counterparts had so long ago. We have to do things differently because the world has changed. The emphasis of our life is different, and so are our health-related activities, which now are aimed at improving and enriching the quality of life of senior citizens, children and youth.

As we live life a little larger, live it with a dream, we should not be discouraged if all the plans we make are not fully accomplished. We will have led our organization one step farther along the way to improving health care delivery for every person and in helping with health education for preventive medicine. We can and must be effective in community leadership in this area by being interested, informed and involved.

We must maintain constant rapport with our doctor husbands, who want to be sure that our health care dollars are spent on programs that produce results. The public is being presented with a very complex and tremendously expensive program with the extravagant claim that drastically rearranging health delivery will make it better and that creating a huge federal bureaucracy is the solution for health care problems. We must become knowledgeable about this, so that we can answer intelligently the questions of neighbors and friends.

Careful planning provides the best results, so as we plan for tomorrow, we must set priorities. One of these would be to help improve the availability of blood. That would not have been a priority in pioneer days, nor even 50 years ago, but the need for blood increases each year because of advances in medical technology.

Another priority is the support of AMAERF, which provides scholarship funds for the education of physicians who deliver the health care programs.

Currently there are about 4,500 doctors in the state. Every wife could be an auxiliary member. We have had as many as 2,900 members in the state auxiliary, but the 2,700 members we currently claim could be increased.

Why should the wife of a doctor become a member-at-large or why should you belong to the state auxiliary? You need to know about the activities of the auxiliary, for its major concern is yours; about important legislation that has health clauses in it; about the activities of other auxiliary members. In union there is strength, and the strength of our state auxiliary is in helping with health education and in doing volunteer work for better health facilities and programs in our communities.

It also should be our goal to educate the public that health is an individual responsibility. Too many of what should be an individual's responsibilities are being assumed—or handed over—to others these days.

We must underscore the need for immunization. The auxiliary could take part in clinics having volunteer services, and we could express as individuals to our friends and the community the need for this important health care aspect.

Personally, I would like to have you make friendship a priority. I would like to stimulate interest in the auxiliary and its goals, and friendship among its members.

I am honored at being your president this year. With your help, we can attain some of these goals and priorities and plan for the future. And on our 100th anniversary, when those members are discussing "The Auxiliary: Yesterday, Today, and Tomorrow," they will speak of us as "our counterparts of long ago, who lived life a little larger, lived it with a dream."

Mary K. (Mrs. John R.) Stanley
President, ISMA Auxiliary

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The Journal

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Indiana Delegation in Congress

UNITED STATES SENATORS

Senior Senator—Hon. Birch E. Bayh, Jr.
(D) 2919 Garfield St. N.W., Washington
363 Russell Office Bldg., Washington 20510
416 Federal Bldg., Indianapolis 46204

Junior Senator—Hon. Richard G. Lugar
(R) 5107 Dirksen Bldg., Washington 20510
46 East Ohio St., Indianapolis 46204

UNITED STATES REPRESENTATIVES

First District—Hon. Adam Benjamin, Jr.
(D) 306 Federal Bldg., 610 Connecticut, Gary 46402
1608 Longworth Bldg., Washington 20515

Second District—Hon. Floyd Fithian
(D) 5 N. Earl Ave., Lafayette 47902
1205 Longworth Office Bldg., Washington 20515

Third District—Hon. John Brademas
(D) 203 Federal Bldg., South Bend 46601
1236 Longworth Bldg., Washington 20515

Fourth District—Hon. Dan R. Quayle
(R) 326 Federal Bldg., Fort Wayne 46802
1407 Longworth Bldg., Washington 20515

Fifth District—Hon. Elwood Hillis
(R) 504 Union Bank Bldg., Kokomo 46901
2429 Rayburn Bldg., Washington 20515

Sixth District—Hon. David W. Evans
(D) P.O. Box 41709, Administration Bldg., Weir Cook
Municipal Airport, Indianapolis 46241
432 Cannon Office Bldg., Washington 20515

Seventh District—Hon. John T. Myers
(R) 107 Federal Bldg., Terre Haute 47808
2448 Rayburn Bldg., Washington 20515

Eighth District—Hon. David L. Cornwell
(D) 210 Sixth St., Evansville 47713
1609 Longworth Bldg., Washington 20515

Ninth District—Hon. Lee H. Hamilton
(D) 2336 Sycamore, Columbus
2202 Rayburn Bldg., Washington 20515

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Because of limited space the committee has set a limitation on scientific exhibits. Consequently, the committee will allocate space on a priority based on date of receipt of the application.

Professional Medical and Allied Organizations

Due to the additional content of the Yearbook, cut-off date for changes in the following groups was in April. Some have changed in the interim. However, it is felt that where officers have changed, a query to those listed here will put interested persons in contact with such groups.

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Community Mental Health Services In the State of Indiana: 1977

DANIEL D. STEINER, ACSW
Indiana Department of Mental Health
Indianapolis

Following is a list of outpatient mental health facilities and comprehensive community mental health centers in the state of Indiana, alphabetized by city of location. The reader who might be interested in additional services (day care, halfway house care, psychological testing and a

more detailed listing of services, staff and application procedure) should consult Daniel D. Steiner, Director of Community Mental Health Services, Department of Mental Health, Five Indiana Square, Indianapolis 46204; 317-633-7558.

Anderson

*The Center for Mental Health, Inc., P.O. Box 1258, 46015, 1616 Meridian St. (317) 642-4968
Thomas A. Fedor, M.D., Medical Director
Richard DeHaven, Administrator

Bloomington

Indiana University Psychological Clinic, Psychology Building, 47401. (812) 337-2311
Leon Levy, Ph.D., Director.
*Community Mental Health Center, 640 South Rogers St., 47401. (812) 339-1691
Herman Brown, Ph.D., Executive Director

Columbus

*Quinco Consulting Center, 2075 Lincoln Park Drive, 47201. (812) 379-2341
Medical Director. None presently
John Carver, Exec. Director

Danville

*Cummins Mental Health Clinic, Inc., 258 Meadow Drive, 46122. (317) 745-5419
Gary D. Beck, ACSW, Director.

East Chicago

*Tri-City Comprehensive Community Mental Health Center, Inc., 3901 Indianapolis Blvd., East Chicago, 46312. (219) 398-7050
Richard E. McPherson, ACSW, Director.

Elkhart

*Oaklawn Community Mental Health Center, Inc., 2600 Oakland Ave., 46514. (219) 294-3551
Otto D. Klassen, M.D., Medical Director.
Hal C. Loewen, Administrator.

Evansville

*Southwestern Indiana Mental Health Center, Inc., 415 Mulberry Street, 47713. (812) 423-7791
Eugene Mittelman, M.D., Ph.D., Executive Director.
Robert M. Spear, Business Administrator.

Fort Wayne

*Mental Health Center at Fort Wayne, Inc., 909 East State Blvd., Fort Wayne 46805. (219) 482-9111
Robert L. Greenlee, M.D., Medical Director.
Richard W. Noel, Administrator.

Gary

Gary Community Mental Health Center, Gary National Bank Bldg., 504 Broadway, 46402. (219) 885-4264
Mr. Robert M. Douglas, Director

Indianapolis

*Long Adult Psychiatry Clinic, Indiana-Purdue University Medical Center, 1100 West Michigan St., 46202. (317) 264-7422
Jack Adair, M.D., Medical Director.

**Central State Hospital Clinic—Alcoholism—3000 West Washington St., 46222. (317) 639-5304
Rosendo G. Transinsin, M.D., Unit Chief.
Mrs. Deanne K. Peer, Administrator.

*Partially supported by the Indiana Department of Mental Health.

**Completely supported by the Indiana Department of Mental Health.

***Child Guidance Clinic of Marion County, Inc.,**
 1949 East 11th St., 46201. (317) 632-5381
 Antonio Recinto, M.D., Medical Director.
 Ben L. Glancy, ACSW }
 Paul Frederickson, M.D. } Co-Directors

Epilepsy Clinic of The Indiana University Medical Center, Fifth Floor, Riley Hospital, 46202. (317) 264-4974

Omkar Markand, M.D., Medical Director.

Episcopal Community Services, Inc., 1537 Central Ave., 46202. (317) 635-2538

Mrs. Anna Hipple, Board President

Gallahue Mental Health Center, 1500 North Ritter Ave., 46219 (317) 353-5414

James Davis, M.D., Medical Director.

Seward A. Horner, Administrator.

****Larue D. Carter Memorial Hospital—Outpatient Clinic,** 1315 West 10th St., 46202. (317) 634-8401

Joseph A. FitzGerald, M.D., Director.

***Midtown Community Mental Health Center,** Wishard Memorial Hospital, 1001 West 10th St., 46202. (317) 630-7791

James J. Wright, M.D., Medical Director.

Dennis Jones, ACSW, Executive Director.

Pediatric-Neurology Clinic (formerly James Whitcomb Riley Memorial Clinic for Intellectually Handicapped Children), First Floor, Riley Hospital, 46202. (317) 264-8747

Arthur L. Drew, M.D., Medical Director.

Regenstrief Health Center, 1001 W. Tenth St., 46202. (317) 630-7363

***Riley Child Guidance Clinic,** Indiana University Medical Center, 1100 West Michigan St., 46202. (317) 264-8162

Donald Churchill, M.D., Director and Administrator.

Jasper

***Southern Hills Mental Health Center, Inc.,** P.O. Box 245, 112 W. 5th Street, 47546. (812) 482-3020

German Gutierrez, M.D., Medical Director.

Robert Flick, MBA, Business Administrator.

Jeffersonville

***Southern Indiana Mental Health and Guidance Center, Inc.,** 207 West 13th Street 47130. (812) 283-4491

Joseph B. Brill, M.D., Medical Director.

John Case, Administrator.

Kendallville

***Northeastern Indiana Psychiatric Clinic, Inc.,** 305 East Wayne 46755 (219) 347-2453

Otto D. Klassen, M.D., Medical Director.

Dale Cochard, Administrator.

Kokomo

Regional Mental Health Center, 3500 S. Lafountain St. 46901. (317) 453-7801

John A. Bowman, M.D., Medical Director.

Gilbert Anderson, Ed.D., Administrator.

Lafayette

Purdue Psychological Services Center, Education Building, Purdue University, West Lafayette 47907. (317) 749-2754

James D. Linden, Ph.D., Director.

Theodore Wachs, Ph.D., Child Clinic Services.

***Wabash Valley Hospital Mental Health Center, Inc.,** 2900 North River Avenue, West Lafayette, Indiana 47906. (317) 463-2555

Richard F. Rahdert, M.D., Medical Director.

Donald Kinzer, Administrator.

LaPorte

***LaPorte County Community Mental Health Center,** 1304 Jefferson Ave., LaPorte 46350 (219) 362-2145

Chester F. McClure, M.D., Medical Director.

Lawrenceburg

***Community Mental Health-Mental Retardation Center, Inc.,** 285 Bielby Rd., Lawrenceburg, 47025. (812) 537-1302

Ronald Myers, M.D., Medical Director.

James Jones, Director.

Logansport

***Guidance Center, Inc.,** 200 Eel River Ave., 46947. (219) 753-6328

James Schalliol, M.D., Medical Director.

Madison

****Madison State Hospital Outpatient Clinic,** Madison, 47250. (812) 265-2611

Donald B. Rogers, M.D., Medical Director.

Ott B. McAtee, M.D., Superintendent.

Marion

***Grant-Blackford County Mental Health Center,** 505 Wabash Ave., 46952. (317) 662-3971

Jiranlal P. Gohil, M.D., Medical Director.

John A. Creek, AB, Acting Executive Director.

Merrillville

Lake Co. Mental Health Clinic, 514 E. 86th Ave., 46410. (219) 769-9460

Krystyna Sklenarz, M.D., Medical Director

Mrs. Mary Redfox, Administrative Assistant

Southlake Community Mental Health Center, 514 East 86th Avenue, 46410. (219) 769-4005

Mr. Lee Strawhun, Executive Director.

Muncie

Comprehensive Mental Health Services of East Central Indiana, Inc., 1525 North Walnut St., 47303. (317) 288-8843

David Wright, Ph.D., Executive Director.

Noblesville

Tri-County Mental Health Foundation, Inc., P.O. Box 363, 1249 Corner St., 46060. (317) 773-6864

Fred Koss, ACSW, Director.

Richmond

*Camilla B. Dunn Mental Health Center, Inc., 54 South 15th St., 47374. (317) 962-1523

Samuel Thornton, Ed.D., Director.

South Bend

*The Mental Health Center of St. Joseph County, Inc., 403-405 E. Madison St., 46617. (219) 289-2884

C. Glenn Harris, M.D., Medical Director.

Joseph Stephens, Administrator.

Terre Haute

*Katherine Hamilton Mental Health Center, 620 Eighth Avenue 47804. (812) 232-1181

William C. Shriner, M.D., Medical Director.

Thomas Barone, Director of Administration.

Valparaiso

*Porter-Starke Services, 701 Wall Street, 46383. (219) 464-8541

Lee Periolet, M.D., Medical Director.

Lee Grogg, Director.

Vincennes

*Vincennes Comprehensive Mental Health Center, Good Samaritan Hospital, 520 South Seventh Street 47591. (812) 885-3291

Frederick H. Buehl, M.D., Medical Director.

Larry L. Burch, ACSW, Assistant Director for Administration

Warsaw

*Five County Mental Health Center, 733 South Buffalo St., 46580. (219) 267-7169

H. Matheu, M.D., Medical Director.

Ben Knott, Ph.D., Administrator.

Federally Approved Rehabilitation Centers in Indiana

CLARK COUNTY

Southeastern Indiana Rehabilitation Center, Inc.

1329 Applegate Lane

Clarksville, 47130

LAKE COUNTY

Trade Winds Rehabilitation Center Inc.

5901 West 7th

Gary, 46406

MARION COUNTY

Crossroads Rehabilitation Center

3242 Sutherland Avenue

Indianapolis 46205

ELKHART COUNTY

Association For The Disabled of Elkhart County, Inc.

PO Box 398

Bristol 46507

VANDERBURGH COUNTY

The Rehabilitation Center, Inc.

3701 Bellemeade Avenue

Evansville 47715



Natural balance doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo*.
- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG 
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert[®]/25 
(meclizine HCl) 25 mg. Tablets
for vertigo*

DYAZIDE[®]

Each capsule contains 50 mg. of Dyrenium[®] (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*

Trademark

**LOWERS
BLOOD
PRESSURE**

**CONSERVES
POTASSIUM**

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

*

WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

*

Indications: When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes (see Warnings).

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyper-

kalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K⁺ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K⁺ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K⁺ frequently; both can cause K⁺ retention and elevated serum K⁺. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia,

thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

SK&F CO., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

Approved Hospitals in Indiana*

April 1, 1977

****INDICATES APPROVED MEDICARE HOSPITAL**

ADAMS COUNTY

****Adams County Memorial Hospital**
805 High Street, Decatur 46733
Mr. Edwin H. Kauffman, Adm.

ALLEN COUNTY

****The Lutheran Hospital of Fort Wayne**
3024 Fairfield Ave., Fort Wayne 46807
Mr. Edgar C. Kruse, President
****Parkview Memorial Hospital, Inc.**
2200 Randalia Dr., Fort Wayne 46805
Mr. Mark Slen, Adm.
****St. Joseph's Hospital of Fort Wayne, Inc.**
700 Broadway, Fort Wayne 46802
Sister M. Kathleen Quinn, Adm.

BARTHOLOMEW COUNTY

****Bartholomew County Hospital**
2400 East 17th St., Columbus 47201
Mr. Robert S. Borczon, Adm.

BLACKFORD COUNTY

****Blackford County Hospital**
503 E. Van Cleve St., Hartford City 47348
Mr. David J. McIntire, Adm.

BOONE COUNTY

****Witham Memorial Hospital**
1124 N. Lebanon St., Lebanon 46052
Mr. John B. Riekema, Adm.

CASS COUNTY

****Memorial Hospital**
1101 Michigan Ave., Logansport 46947
Mr. Herbert L. Fromm, Executive Director

CLARK COUNTY

****Clark County Memorial Hospital**
1220 Missouri Ave., Jeffersonville 47130
Mr. Benedict Heslen, Adm.
****North Clark Community Hospital**
State Road 3, Charlestown 47111
Mr. Robert N. Shaw, Exec. Dir.

CLAY COUNTY

****Clay County Hospital**
1206 E. National Ave., Brazil 47834
Mr. Richard Denney, Adm.

CLINTON COUNTY

****Clinton County Hospital**
1300 S. Jackson St., Frankfort 46041
Mr. William J. Russell, Adm.

DAVIESS COUNTY

****Davie County Hospital**
1314 Grand Ave., Washington 47501
Mr. William D. Gibson, Adm.

DEARBORN COUNTY

****Dearborn County Hospital**
600 Wilson Creek Rd., Lawrenceburg 47025
Mr. Daniel J. Rissing, Adm.

DECATUR COUNTY

****Decatur County Memorial Hospital**
720 N. Lincoln St., Greensburg 47240
Mr. Jack A. Peters, Executive Director

DEKALB COUNTY

****DeKalb Memorial Hospital, Inc.**
East Seventh St., Auburn 46706
Mr. L. C. Baker, Adm.
****Garrett Community Hospital, Inc.**
1367 S. Randolph St., Garrett 46738
Mrs. Mary Lou McPheeters, Acting Adm.

DELAWARE COUNTY

****Ball Memorial Hospital Association, Inc.**
2401 University Ave., Muncie 47303
Mr. Roy F. Erickson, Pres.

DUBOIS COUNTY

****Memorial Hospital**
(Little Company of Mary of Indiana, Inc.)
800 West 9th St., Jasper 47546
Mr. Herman A. Kohlman, Executive Director
****St. Joseph's Hospital**
Leland Heights, Huntingburg 47542
Mr. Norman Wright, Adm.

ELKHART COUNTY

****Elkhart General Hospital**
600 East Boulevard, P.O. Box 329, Elkhart 46514
Mr. Dale S. Strassheim, Pres.
****Goshen General Hospital**
200 High Park Avenue, Goshen 46526
Mr. Warren O. Phemister, Adm.

FAYETTE COUNTY

****Fayette Memorial Hospital Association, Inc.**
1941 Virginia Ave., Connersville 47331
Mr. James E. Cooper, Acting Adm.

FLOYD COUNTY

****Memorial Hospital of Floyd County**
1850 State St., New Albany 47150
Mr. William I. Fender, Adm.

*Approved by the Indiana Council for Hospital Licensure
and the Indiana State Board of Health.

FULTON COUNTY

****Woodlawn Hospital of Rochester, Indiana**
624 Pontiac St., Rochester 46975
Mr. Robert E. Kelsey, Jr., Adm.

GIBSON COUNTY

****Gibson General Hospital**
1808 Sherman Drive, Princeton 47670
Mr. Howard F. Vire, Adm.

****Wirth Osteopathic Hospital**
Highway 64, West, Oakland City 47660
Mr. Bruce G. Steiner, Acting Adm.

GRANT COUNTY

****Marion General Hospital**
Wabash at Euclid, Marion 46952
Mr. John W. Green, Adm.

GREENE COUNTY

Greene County General Hospital
R.R. 1, Lone Tree Road & Hwy. 54E, Linton 47441
Mr. Malcolm M. Clippinger, Adm.

HAMILTON COUNTY

****Riverview Hospital**
395 Westfield Rd., Noblesville 46060
Mr. Peter R. Mariani, Adm.

HANCOCK COUNTY

****Hancock County Memorial Hospital**
800 North State Street, P.O. Box 827, Greenfield 46140
Mr. John B. White, Adm.

HARRISON COUNTY

****Harrison County Hospital**
R.R. 6, Box 75, Corydon 47112
Mr. John T. Vie, Adm.

HENDRICKS COUNTY

****Hendricks County Hospital**
1000 E. Main St., Danville 46122
Mr. Dennis W. Dawes, Adm.

HENRY COUNTY

****Henry County Memorial Hospital**
1000 N. 16th, P.O. Box 490, New Castle 47362
Mr. Jack J. Balser, Adm.

HOWARD COUNTY

****Howard Community Hospital**
3500 S. LaFountain St., Kokomo 46901
Mr. George R. Banjak, Adm.
****St. Joseph Memorial Hospital of Kokomo, Ind., Inc.**
1907 W. Sycamore St., Kokomo 46901
Sister M. Martin C.S.J., Adm.

HUNTINGTON COUNTY

****Huntington County Hospital**
1215 Etna Ave., Huntington 46750
Mr. Leigh E. Morris, Exec. Dir.

JACKSON COUNTY

****Jackson County Schneck Memorial Hospital**
200 S. Walnut St., Seymour 47274
Mr. George H. James, Jr., Adm.

JASPER COUNTY

****Jasper County Hospital**
East Grace St., Rensselaer 47978
Mr. Jack M. Corey, Adm.

JAY COUNTY

****Jay County Hospital**
505 W. Arch St., Portland 47371
Mr. L. Paul Grummer, Adm.

JEFFERSON COUNTY

****The King's Daughters' Hospital**
112 Presbyterian Ave., Madison 47250
Mr. W. A. McAlexander, Adm.

JENNINGS COUNTY

Jennings Community Hospital
301 Henry St., North Vernon 47265
Mr. Allen J. Perez, Jr., Adm.

JOHNSON COUNTY

Indiana Masonic Home Hospital
690 South State St., Franklin 46131
Mr. Harold Miller, Jr., Adm.

****Johnson County Memorial Hospital**
P.O. Box 368, Franklin 46131
Mr. George P. Goshorn, Adm.

KNOX COUNTY

****Good Samaritan Hospital**
520 S. Seventh St., Vincennes 47591
Mr. Charles Arends, Adm.

KOSCIUSKO COUNTY

****Kosciusko Community Hospital, Inc.**
2101 East Dubois Drive, Warsaw 46580
Mr. L. Milton Holmgren, Adm.
****Murphy Medical Center, Inc.**
Buffalo at Winona Ave., Warsaw 46580
Mr. Robert A. Berryman, Adm.

LAGRANGE COUNTY

****LaGrange County Hospital**
Townline Road, La Grange 46761
Mrs. Elsie R. Willard, Adm.

LAKE COUNTY

Broadway Methodist Hospital
8701 Broadway, Merrillville 46410
Mr. R. B. Glesne, Adm.
****Our Lady of Mercy Hospital**
U. S. Highway 30, Dyer 46311
Sister Mary Marcia Wilhelmi, R.S.M., Adm.
St. Anthony Medical Center
Main and Franciscan Rd., Crown Point 46307
Mr. Lawrence T. Filosa, Pres.
****St. Catherine Hospital of East Chicago**
4321 Fir St., East Chicago 46312
Sister M. Stephen Brueggeman, Adm.
****The Methodist Hospital of Gary, Inc.**
600 Grant Street, Gary 46402
Mr. R. B. Glesne, Adm.

****St. Mary Medical Center, Inc.**

540 Tyler St., Gary 46402

Mr. Paul R. Kaiser, Adm.

****St. Margaret Hospital**

25 Douglas St., Hammond 46320

Sister M. Doris Hodges, O.S.F., Adm.

****St. Mary Medical Center, Inc.**

1500 S. Lake Park Ave., Hobart 46342

Mr. Paul R. Kaiser, Adm.

****The Community Hospital**

(Munster Medical Research Department)

901 MacArthur Blvd., Munster 46321

Mr. Edward P. Robinson, Adm.

LAPORTE COUNTY

****LaPorte Hospital, Inc.**

State and Madison Avenues, LaPorte 46350

Mr. David D. Kramer, Adm.

****Memorial Hospital of Michigan City**

5th and Pine Sts., Michigan City 46360

Mr. Norman D. Steider, Adm.

****St. Anthony Hospital**

301 W. Homer St., Michigan City 46360

Sister Mary Agnes Zinselmeyer, Adm.

****Walters Hospital Foundation, Inc.**

3714 S. Franklin St., Michigan City 46360

Mr. Donald Muhlenenthaler, Adm.

LAWRENCE COUNTY

****Bedford Medical Center**

2900 W. 16th Street, Bedford 47421

Mr. Donald W. Dodds, Adm.

****Dunn Memorial Hospital**

1616 23rd St., Bedford 47421

Mr. Richard G. Shedd, Adm.

MADISON COUNTY

****Community Hospital of Anderson and
Madison County**

1515 N. Madison Ave., Anderson 46012

Mr. Paul H. Ward, Jr., Adm.

****Mercy Hospital, Inc.**

1331 South "A" St., Elwood 46036

Mr. Edward J. Tapek, Adm.

****St. Johns' Hickey Memorial Hospital**

2015 Jackson, Anderson 46014

Sister Mary Brooks, C.S.C., Adm.

MARION COUNTY

****Community Hospital of Indianapolis, Inc.**

1500 N. Ritter Ave., Indianapolis 46219

Allen M. Hicks, Pres.

****Indiana University Hospital**

1100 W. Michigan St., Indianapolis 46202

Mr. Ralph W. Kletzien, Acting Dir.

****Methodist Hospital of Indiana, Inc.**

1604 N. Capitol Ave., Indianapolis 46202

Mr. Jack A. L. Hahn, President

****St. Francis Hospital Center**

1600 Albany St., Beech Grove 46107

Sister M. Sponsaria Doerger, O.S.F., Exec. Dir.

Mr. Don D. Hamachek, Adm.

****St. Vincent Hospital**

2001 W. 86th St., Indianapolis 46260

Sister Gertrude Bastnagel, D.C., Adm.

****University Heights Hospital, Inc.**

3350 Carson Ave., Indianapolis 46227

Mr. Raymond E. Laughlin, Adm.

Westview Osteopathic Medical Hospital

3630 Guion Rd., Indianapolis 46222

Mr. James F. Knopp, Adm.

****Winona Memorial Hospital**

3232 N. Meridian St., Indianapolis 46208

Mr. Ryland P. Davis, Exec. Vice Pres.

Wishard Memorial Hospital

1001 W. 10th St., Indianapolis 46202

Robert Van Hoeck, M.D., Medical Director

Mr. William I. Jenkins, Adm.

MARSHALL COUNTY

****Community Hospital of German Township, Inc.**

411 W. Grant St., Bremen 46506

Mr. Roy M. Foltin, Adm.

****Marshall County Parkview Hospital**

1401 N. Michigan St., Plymouth 46563

Mr. Martin P. Braaksma, Exec. Dir.

MIAMI COUNTY

****Dukes Memorial Hospital**

Grant and Boulevard, Peru 46970

Mr. Robert L. Allman, Adm.

MONROE COUNTY

****Bloomington Hospital**

605-625 W. Second St., Bloomington 47401

Mr. Roland E. Kohr, Adm.

MONTGOMERY COUNTY

****Montgomery County Culver Union Hospital**

306 Binford St., Crawfordsville 47933

Mr. William Stoltz, Adm.

MORGAN COUNTY

****The Margaret Kendrick Memorial Hospital, Inc.**

1201 Hadley Road, Mooresville 46158

Mrs. Louise D. Swisher, Adm.

****Morgan County Memorial Hospital**

2209 John R. Wooden Dr., Martinsville 46151

Mr. Kenneth G. Stella, Adm.

NEWTON COUNTY

****George Ade Memorial Hospital**

Highway 16, Brook 47922

Mr. Paul C. Poparad, Adm.

NOBLE COUNTY

****McCray Memorial Hospital**

Hospital Drive, Kendallville 46755

Mr. Richard H. Mills, Adm.

ORANGE COUNTY

****Orange County Hospital**
Sandy Hook Road, Paoli 47454
Mr. W. Lavelle Garritson, Adm.

PERRY COUNTY

****Perry County Memorial Hospital**
Box H. Tell City 47586
Mr. Lawrence A. Welch, Adm.

PORTER COUNTY

****Porter Memorial Hospital**
814 LaPorte Ave., Valparaiso 46383
Mr. Arthur S. Malasto, Adm.

PULASKI COUNTY

****Pulaski Memorial Hospital**
616 East 13th St., Winamac 46996
Mr. Theodore H. Kittell, Ph.D., Adm.

PUTNAM COUNTY

****Putnam County Hospital**
330 Greenwood Ave., Greencastle 46135
Mr. Arthur B. Allaben, Adm.

RANDOLPH COUNTY

****Randolph County Hospital**
Oak St. and Greenville Ave., Winchester 47394
Mr. Bryan R. Zeh, Adm.
****Union City Memorial Hospital Association**
900 N. Columbia St., Union City 47390
Mr. Michael S. Shaffer, Adm.

RIPLEY COUNTY

****Margaret Mary Community Hospital**
Mitchel Ave., Batesville 47006
Mr. Wilbur L. Mauzy, Adm.

RUSH COUNTY

****Rush Memorial Hospital**
1300 N. Main St., Rushville 46173
Mr. Karl F. Stein, Adm.

ST. JOSEPH COUNTY

****Healthwin Hospital**
20531 West Darden Road, South Bend 46637
Mr. Donald F. Henry, Adm.
****Memorial Hospital of South Bend**
615 N. Michigan St., South Bend 46601
Mr. Richard W. Trenkner, Adm.
****St. Joseph Hospital of Mishawaka, Indiana, Inc.**
215 W. 4th St., Mishawaka 46544
Sister M. Maureen Freihage, Adm.
****St. Joseph's Hospital**
811 E. Madison St., South Bend 46634
Mr. David C. Trew, Adm.
****South Bend Osteopathic Hospital**
2515 E. Jefferson Blvd., South Bend 46615
A. F. Kull, D.O., President
Mr. Stanley J. Fleece, Adm.

SCOTT COUNTY

****Scott County Memorial Hospital**
R.R. 1, Box 19, Scottsburg 47170
Mr. George Ramsey, Adm.

SHELBY COUNTY

****William S. Major Hospital**
150 W. Washington St., Shelbyville 46176
Mr. Frank H. Learned, Adm.

STARKE COUNTY

****Starke Memorial Hospital**
102 E. Culver Road, Knox 46534
Mr. James W. Gordon, Adm.

STEUBEN COUNTY

****Cameron Memorial Community Hospital**
416 East Maumee St., Angola 46703
Mr. Ronald D. Showalter, Adm.

SULLIVAN COUNTY

****Mary Sherman Hospital**
320 N. Section St., Sullivan 47882
Mr. William H. Sluder, Adm.

TIPPECANOE COUNTY

****Lafayette Home Hospital, Inc.**
2400 South St., Lafayette 47902
Mr. Franklin E. Simek, Adm.
Purdue University Student Hospital
West Lafayette 47907
Loyal W. Combs, M.D., Dir.
****St. Elizabeth Hospital**
1501 Hartford Street, Lafayette 47904
Mr. Paul E. Hess, Adm.

TIPTON COUNTY

****Tipton County Memorial Hospital**
1000 South Main Street, Tipton 46072
Mr. James C. Talley, Adm.

VANDERBURGH COUNTY

****Deaconess Hospital, Inc.**
600-700 Mary St., Evansville 47747
Mr. David A. Johnson, Adm.
****St. Mary's Hospital, Inc.**
3700 Washington Ave., Evansville 47750
Sister Theresa Peck, Adm.
****Welborn Memorial Baptist Hospital, Inc.**
401 S.E. 6th St., Evansville 47713
Mr. Donald I. Gent, Executive Dir.

VERMILLION COUNTY

****Vermillion County Hospital**
801 S. Main St., Clinton 47842
Mr. Gerald C. Dooley, Adm.

VIGO COUNTY

Terre Haute Regional Hospital
1021 S. 6th St., Terre Haute 47808
Mr. Allyn R. Harris, Adm.
****Union Hospital, Inc.**
1606 N. 7th St., Terre Haute 47804
Mr. Frank Shelton, Adm.

WABASH COUNTY

****Wabash County Hospital**
670 N. East St., Wabash 46992
Mr. Wayne Hendrix, Adm.

WARREN COUNTY

****Community Hospital Assn., Inc.**
412 N. Monroe St., Williamsport 47993
Mrs. Norma Hillyer, R.N., Adm.

WARRICK COUNTY

Warrick Hospital, Inc.
1116 Millis Ave., Boonville 47601

WASHINGTON COUNTY

****Washington County Memorial Hospital**
911 N. Shelby Street, Salem 47167
Mr. Rodney M. Coats, Adm.

WAYNE COUNTY

****Reid Memorial Hospital**
1401 Chester Blvd., Richmond 47374
Mr. Kenneth R. Spoon, Adm.

WELLS COUNTY

****Caylor-Nickel Hospital, Inc.**
309 S. Main St., Bluffton 46714
Mr. Paul H. Neely, Adm.

****Wells Community Hospital**
1100 S. Main St., Bluffton 46714
Mr. Paul Bender, Adm.

WHITE COUNTY

****White County Memorial Hospital**
1101 O'Connor Blvd., Monticello 47960
Mr. William R. Saunders, Adm.

WHITLEY COUNTY

****Whitley County Memorial Hospital**
353 N. Oak St., Columbia City 46725
Mr. Robert L. McConnell, Adm.

Ambulatory Outpatient Surgical Centers

ALLEN COUNTY

Fairfield Surgical Center—2828 Fairfield Avenue, Fort Wayne 46807
Administrator: Wayne S. Miller, M.D.
Fort Wayne Surgical Center, Inc., 1333 Maycrest Drive, Fort Wayne 46805
Administrator: Charles T. Frissell, D.D.S.

MARION COUNTY

Indianapolis Women's Center, 5626 East 16th St., Indianapolis 46218
Director: Ralph T. Streeter, M.D.

Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of **The Journal**. Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.

Federally Approved Home Health Services Agencies in Indiana

ALLEN COUNTY

Indiana Homemakers Inc.
2250 Lake Ave., Fort Wayne 46805
Visiting Nurses Service of Fort Wayne, Inc.
227 E. Washington Blvd., Fort Wayne 46802

BARTHOLOMEW COUNTY

Bartholomew County Health Department Home Health Service
2402 East 17th St., Columbus 47201

CASS COUNTY

Home Care Program of Memorial Hospital
1101 Michigan Ave., Logansport 46947

CLARK COUNTY

Clark County Health Department
North Clark Memorial Hospital, 3rd Floor, Charlestown 47111

DAVISS COUNTY

Quad County Visiting Nurse Association, Inc.
508 Highland, Washington 47501

DELAWARE COUNTY

Visiting Nurse Association, Inc.
2500 Bethel Avenue, Muncie 47304
Indiana Homemakers Inc.
Rose Court Bldg., Suite 203, Muncie 47305

ELKHART COUNTY

Nursing Division, Elkhart County Health Unit
2400 E. Elkhart Rd., Goshen 46526

GRANT COUNTY

Grant County Visiting Nurse Association, Inc.
116 Cherry St., Marion 46952

HANCOCK COUNTY

East Side Home Care
R. R. #7, Box 70, Greenfield 47140

HUNTINGTON COUNTY

Huntington County Home Health Agency, Huntington Memorial Hospital
1215 Etna Avenue, Huntington 46750

JACKSON COUNTY

Home Health Care Division, Jackson County Department of Health, Jackson County Hospital
Poplar & Bruce Streets, Seymour 47274

JEFFERSON COUNTY

Home Health Division, Jefferson County Health Dept.
315 E. Second St., Madison 47250

JOHNSON COUNTY

Division of Nursing, Johnson County Health Dept.
2 E. Jefferson, Franklin 46131

LAKE COUNTY

Home Care Department, Lake County Health Dept.
2293 N. Main, Crown Point 46307
Home Nursing Service
United Health Program,
Calumet Area, Inc.
111 Sibley St., Hammond 46320
Northwest Indiana Home Health Services
Visiting Nurse Association, Inc.
6513 Kennedy Avenue, Hammond 46323
Northern Indiana Home Health Services, Inc.
3290 Grant Street, Gary 46408

LAPORTE COUNTY

Visiting Nurses Association of LaPorte County, Inc.
903 Indiana Ave., LaPorte 46350

MADISON COUNTY

Visiting Nurse Inc., Board of Directors of Elwood
1331 South "A" Street, Elwood 46036

MARION COUNTY

Indiana Homemakers, Inc.
6352 N. Guilford, Indianapolis 46220
Visiting Nurse Association of Greater Indianapolis, Inc.
615 N. Alabama St., Indianapolis 46204
Home Care Agency of Greater Indpls., Inc.
1717 W. 86th St., Indianapolis 46260
Medical Personnel Pool of Indpls., Inc.
300 E. Fall Creek Pkwy.—North Drive, Indianapolis 46205

MONROE COUNTY

Public Health Nursing Assn. of Bloomington & Monroe County, Inc.
315 W. Dodds St., Bloomington 47401

PORTER COUNTY

Visiting Nurse Association of Porter County, Inc.
755 W. Lincolnway, Valparaiso 46383

RUSH COUNTY

Rush County Home Health Services
Rush County Health Dept.
Courthouse, Room 5, Rushville 46175

ST. JOSEPH COUNTY

Indiana Homemakers, Inc.
120 W. LaSalle, Rm. 1104, South Bend 46601
Visiting Nurses Assn. of St. Joseph County, Inc.
321 Lincolnway West, South Bend 46601

SCOTT COUNTY

Home Care Division, Scott County Health Department
R.R. 2, Scottsburg 47170

SULLIVAN COUNTY

Home Care Agency, Mary Sherman Hospital
320 North Section Street, Sullivan 47882

TIPPECANOE COUNTY

Visiting Nursing Service of Lafayette, Inc.
1114 State St., Lafayette 47905

VANDERBURGH COUNTY

Visiting Nurse Association of Southwestern Indiana, Inc.
120 S.E. First St., Evansville 47713

VIGO COUNTY

Visiting Nurse Assn. of Terre Haute, Inc.
328 S. Fifth St., Terre Haute 47807
Wabash Valley Home Health Care
1310 S. 3rd St., Terre Haute 47808

WAYNE COUNTY

Wayne County Health Department
15 N. Tenth St., Richmond 47374

Medicare Approved Independent Clinical Laboratories—1977

ALLEN COUNTY

Duemling Clinic Laboratory
2828 Fairfield Ave.
Fort Wayne 46807

University Park Medical Clinic
5110 N. Clinton St.
Fort Wayne 46805

General Analytical Laboratories, Inc.
5015 Speedway Drive
Fort Wayne 46805

Lake Avenue Medical Laboratory
3217 Lake Ave.
Fort Wayne 46805

Ft. Wayne Medical Laboratory Corp.
519 Medical Center Building
347 W. Berry St., P.O. Box 268
Fort Wayne 46802

New Haven Medical Laboratory
1010 Werling Road
New Haven 46774

BARTHOLOMEW COUNTY

Columbus Medical Laboratory
Doctors Park—Building #2
Columbus 47201

DELAWARE COUNTY

Pathologists Associated
407 W. Main St.
Muncie 47305

FLOYD COUNTY

Professional Arts Laboratory
Professional Arts Bldg., Suite 20
1919 State St.
New Albany 47105

GREENE COUNTY

Haag Medical Laboratory
120 E. Vincennes St.
Linton 47441

JOHNSON COUNTY

Greenwood Medical Laboratory, Inc.
622 N. Madison Ave.
Greenwood 46142

KNOX COUNTY

Vincennes Doctors' Laboratory
704 Vigo St.
Vincennes 47591

LAKE COUNTY

Crown Point Clinical Laboratory
113 N. Court St.
Crown Point 46307

DeGraff Pathology Laboratory
8237 Forest Avenue
Munster 46321

Lake Ridge Medical Laboratory, Inc.

1573 N. Cline Ave.
Griffith 46319

Gary Clinical Laboratory

504 Broadway
Gary 46402

Gary Medical Center Clinical Laboratories

3290 Grant St.
Gary 46409

Diagnostic Laboratory, Inc.

3275 Broadway
Gary 46409

LAPORTE COUNTY

Northern Indiana Medical Laboratory Services, Inc.

1701 Buffalo St., P.O. Box 341
Michigan City 46360

MADISON COUNTY

Anderson Medical Laboratories, Inc.

333 Jackson St.
Anderson 46012

MARION COUNTY

AccuSTAT Medical Laboratories, Inc.

333 Jackson Street
Anderson 46012

Indianapolis Medical Laboratory, Inc.

8501 Zionsville Rd.
Indianapolis 46268

Irvington Medical Laboratory

6051 E. Washington St.
Indianapolis 46219

Madison Village Laboratory

7210 Madison Ave.
Indianapolis 46227

**The Medical Laboratory of Drs. Thornton, Haymond,
Costin, Buehl & Bolinger**

301 E. 38th St.
Indianapolis 46205

Pathlabs, Inc.

5420 N. College Ave.
Indianapolis 46220

Professional Associates, Inc. d/b/a

Memorial Clinic of Indianapolis

3266 N. Meridian Street
Indianapolis 46208

MARSHALL COUNTY

**deGraffenried, Fisher & Sternberg Medical Consultation
Service**

225 W. Jefferson Street
Plymouth 46563

ST. JOSEPH COUNTY

Medical Arts Laboratory

303 S. Main St.
Mishawaka 46544

South Bend Medical Foundation, Inc.

531 N. Main St.
South Bend 46601

TIPPECANOE COUNTY

Physicians Clinical Laboratory, Inc.

2500 Ferry St.
Lafayette 47904

VANDERBURGH COUNTY

BioClinical Laboratories

2353 Division St.
Evansville 47714

Francis W. Porro, M.D., Clinical Laboratory

3700 Bellemeade Ave., Suite 119
Evansville 47715

Mid-America Pathology Service, Inc.

3700 Bellemeade Ave.
P.O. Box 138
Evansville 47701

Pathology Laboratory Service

611 Harriett St., Suite 102
Evansville 47710

*Community Agencies for the Mentally Retarded and Other Developmentally Disabled**

ADAMS-WELLS COUNTY

Adams-Wells Association for Retarded Citizens, Inc.
R.R. 3, Box 213A, Bluffton 46714

ALLEN COUNTY

Allen County Association for the Retarded, Inc.
2542 Thompson Ave., Fort Wayne 46807
Anthony Wayne Rehabilitation Center for Handicapped
and Blind, Inc.
2826 S. Calhoun St., Fort Wayne 46807

BARTHOLOMEW COUNTY

Developmental Services, Inc.
P.O. Box 1023, 422 Washington, Columbus 47201

CASS COUNTY

Cass County Council for The Mentally Retarded, Inc.
1416 Woodlawn Ave., Logansport 46947

CLARK COUNTY

Council for Retarded Children of Clark County, Indiana,
Inc.
P.O. Box 486, Jeffersonville 47130
Southeastern Indiana Rehabilitation Center
1329 Applegate Lane, Clarksville 47130

DAVISS COUNTY

Daviess-Martin County Association for Handicapped Citizens, Inc.
1412 Memorial Ave., Washington 47501

DEARBORN COUNTY

Community Mental Health-Mental Retardation Center, Inc.
285 Bielby Road, Lawrenceburg, 47025

DeKALB COUNTY

Community Pre-School for Handicapped Children of DeKalb Co., Inc.
Box 166, Auburn 46706

DELAWARE COUNTY

Delaware County Association for Retarded Citizens, Inc.
114 E. Streeter Ave., P.O. Box 848, Muncie 47305
2420 S. Mock—P.O. Box 848, Muncie 47305

ELKHART COUNTY

Association for the Disabled of Elkhart County, Inc.
P.O. Box 398, Bristol 46507

FAYETTE-UNION COUNTIES

Fayette-Union Association for Retarded, Inc.
420 West 24th St., Connersville 47331

FLOYD COUNTY

Floyd County Council for the Retarded, Inc.
Shrader and Abby-Dell Aves., New Albany 47150

FULTON COUNTY

Fulton County Association for Retarded Children, Inc.
East 18th St., Rochester 46975

GIBSON COUNTY

Gibson County Association for Retarded Citizens, Inc.
Prince and Pinkney, Box 505, Princeton 47670

GRANT COUNTY

Grant-Blackford Mental Retardation, Inc.
2715 S. Western Ave., Marion 46952

HAMILTON COUNTY

Hamilton County Association for Special Citizens, Inc.
P. O. Box 361, Noblesville 46060

HANCOCK COUNTY

Hancock County Association for Retarded Children, Inc.
802 North A Street, Greenfield 46140

HARRISON COUNTY

Harrison County Association for Retarded Children, Inc.
Palmyra 47164

HENRY COUNTY

Henry County Association for Retarded Citizens, Inc.
1343 South 14th St., New Castle 47362

HOWARD COUNTY

Howard County Association for Retarded Citizens, Inc.
1220 East Laguna St., Kokomo 46901

HUNTINGTON COUNTY

Huntington County Association for Retarded Citizens, Inc.
P.O. Box 1001, Huntington 46750

JAY COUNTY

Jay-Randolph Developmental Services, Inc.
E. Water St., Portland 47371

JOHNSON COUNTY

Johnson County Association for Retarded Citizens, Inc.
214 S. State St., Franklin 46131

KNOX COUNTY

Knox County Association for Retarded Citizens, Inc.
525 North Fourth St., Vincennes 47591

KOSCIUSKO COUNTY

Council for the Retarded of Kosciusko County, Inc.
504 N. Bay Dr., Warsaw 46580

LaGRANGE COUNTY

LaGrange County Association for Retarded Citizens, Inc.
Box 192, LaGrange 46761

*Compiled by the Indiana Department on Mental Retardation, and Other Developmental Disabilities, 5 Indiana Square, Indianapolis 46204.

LAKE COUNTY

Lake County Association for The Retarded, Inc.
2650 W. 35th Ave., Gary 46408

Trade Winds Rehabilitation Centers, Inc.
5901 West 7th Ave., Gary 46406

LAPORTE COUNTY

LaPorte County Sheltered Workshop, Inc.
4315 E. Michigan Blvd., Michigan City 46360

Parents' Council for Handicapped and Retarded Children of LaPorte County, Inc.
3200 S. Cleveland Ave., Michigan City 46360

MADISON COUNTY

Madison County Association for Retarded Citizens, Inc.
P.O. Box 31, Anderson 46015

MARION COUNTY

Marion County Association for Retarded Citizens, Inc.
2400 N. Tibbs Ave., Indianapolis 46222

Goodwill Industries of Central Indiana, Inc.
1635 W. Michigan St., Indianapolis 46222

Section of Metabolism and Genetics, Dept. of Pediatrics, I.U. School of Medicine
1100 W. Michigan St., Indianapolis 46202

MARSHALL-STARKE COUNTIES

Marshall-Starke Development Center, Inc.
1901 Pidco Drive, Plymouth 46563

MONROE COUNTY

Stonebelt Council for Retarded Children, Inc.
2815 E. 10th, Bloomington 47401

MONTGOMERY COUNTY

Disabilities Services, Inc.
Ben Hur Building, Crawfordsville 47933

MORGAN COUNTY

Morgan County Rehabilitation Services, Inc.
190 W. Mitchell Ave., Martinsville 46151

NOBLE COUNTY

Noble County Association for Retarded Citizens, Inc.
205 East Highland Street, Albion 46701

ORANGE COUNTY

Orange County Association for Retarded Citizens, Inc.
P.O. Box 143, Paoli 47454

PARKE COUNTY

Child-Adult Retardation Services, Inc.
P.O. Box 96, Rockville 47872

PIKE COUNTY

Pike County Association for Retarded Citizens
c/o Knox County Association for Retarded Citizens, P.O.
Box 334, Vincennes 47591

PORTER COUNTY

Porter County Association for Retarded Citizens, Inc.
816 Union St., Valparaiso 46383

PULASKI COUNTY

Pulaski Association for Retarded Children, Inc.
R.R. 2, Winamac 46996

PUTNAM COUNTY

Putnam County Learning Center, Inc.
Box 504, Greencastle 46135

RIPLEY COUNTY

New Horizons Rehabilitation, Inc.
P.O. Box 98, Batesville 47006

SHELBY COUNTY

Handicapped, Inc.
157 East Broadway, Shelbyville 46176

STEBEN COUNTY

Community Sheltered Workshop of Steuben County, Inc.
502 Weatherhead St., Angola 46703

ST. JOSEPH COUNTY

Council for the Retarded of St. Joseph County, Inc.
1235 N. Eddy St., South Bend 46624

SULLIVAN COUNTY

Sullivan County Association for Retarded Children, Inc.
424 East Hartley Street, Sullivan 47882

TIPPECANOE COUNTY

Wabash Center for the Mentally Retarded, Inc.
2000 Greenbush St., Lafayette 47904

VANDERBURGH COUNTY

Evansville Association for Retarded Citizens, Inc.
615 W. Virginia St., Evansville 47710
The Rehabilitation Center, Inc.
3701 Bellemeade Ave., Evansville 47715
Tri-State Epilepsy Association, Inc.
421 North Main St., Evansville 47711

VIGO COUNTY

Katherine Hamilton Mental Health Center, Inc.
620 8th Avenue, Terre Haute 47804

WABASH COUNTY

Wabash County Council for Mentally Retarded and Vocationally Handicapped, Inc.
421 West Canal St., Wabash 46992

WARRICK COUNTY

Southern Indiana Retardation Services, Inc.
Route 3, Folsomville Rd., Boonville 47601

WAYNE COUNTY

Wayne County Council for Retarded Citizens, Inc.
800 Mendleson Dr., Richmond 47374

WHITE COUNTY

Comprehensive Developmental Centers, Inc.
900 West Norway Road, Monticello 47960

WHITLEY COUNTY

Whitley County Association for the Retarded, Inc.
445 South Line, Columbia City 46725

Indiana Licensed Health Facilities

January 1977

This is a directory of health facilities licensed by the State of Indiana, State Board of Health.

Information concerning services offered, charges and admission policies of the facilities should be obtained through direct contact with the facility. Information concerning licensing of health facilities and copies of the directory (which includes data as to capacity and telephone number) are available from the Indiana State Board of Health, Division of Health Facilities, 1330 W. Michigan St., Indianapolis 46206.

Identification Code

- (R) — Residential Care Facility
- (C) — Comprehensive Nursing Care Facility
- (R&C) — Residential Care and Comprehensive Nursing Care Facility
- (R&BHA) — Residential Care and Boarding Home for the Aged Facility
- (BHA) — Boarding Home for the Aged Facility
- (BHA&C) — Boarding Home for the Aged and Comprehensive Nursing Care Facility
- Adm. — Person in direct charge of facility

ADAMS COUNTY

Adams County Home (R)
Route 6, Decatur 46733
Leo and Betty Feasel, Adms.

Berne Nursing Home (R&C)
906 W. Main St., Berne 46711
Pauline Hostetler, L.P.N., Adm.

Decatur Community Care Center (C)
1145 Mercer Ave., Decatur 46733
Jane C. Aspy, Adm.

Swiss Village, Inc. (R&C)
P.O. Box 363, Berne 46711
Wayne Smith, Adm.

ALLEN COUNTY

Byron Health Center (BHA&C)
12101 Lima Rd., R. R. 13,
Fort Wayne 46808
Thomas A. Katsanis, Adm.

Colonial Crest Convalescent Center (C)
2940 N. Clinton St., Fort Wayne 46805
Martin Hipschman, Adm.

Crow's Haven Nursing Home (C)
2440 Bowser Ave., Fort Wayne 46803
Lyle B. Crow and Jeanne E.
Crow, Adms.

Fort Wayne Nursing Home (C)
2402 N. Beacon, Fort Wayne 46805
Margaret Walls, R.N., Adm.

Glenacres Nursing Home, Inc. (C)
3420 E. State St., Fort Wayne 46805
Casto Ball, Adm.

Golden Years Homestead (R&C)
8300 Maysville Road, Fort Wayne 46805
Thomas G. Garman, Adm.

Heritage Manor Nursing Home (C)
7519 Winchester Rd., Ft. Wayne 46819
Norman L. Savage, Adm.

Indian Village Health Center (C)
2237 Engle Road, Fort Wayne 46809
Elizabeth Szegedy, Ph.D., Adm.

Lawton Nursing Home, Inc. (C)
1649 Spy Run Ave., Fort Wayne 46805
Herman H. Aspacher, Adm.

Lutheran Homes, Inc. (R&C)
6701 S. Anthony Blvd., Ft. Wayne 46806
Fred Nieno, Adm.

Parnell Park Nursing Home (C)
3811 Parnell Ave., Ft. Wayne 46805
Diane D. Kelly, Adm.

Saint Anne Home (C)
1900 Randalia Dr., Ft. Wayne 46805
Joseph E. Weingartner, Adm.

Towne House Health Center (R&C)
5544 E. State Blvd., Fort Wayne 46805
Edwin C. Gordon, Adm.

Turtle Creek Convalescent Centre of Fort Wayne-North (C)
2001 Hobson Rd., Fort Wayne 46805
Patricia Brandt, Adm.

Turtle Creek Convalescent Centre of Fort Wayne South (C)
2626 Fairfield Ave., Fort Wayne 46807
John August, Adm.

University Park Nursing Center (C)
1400 Medical Park Dr.,
Fort Wayne 46805
Robert Shambaugh, Adm.

BARTHOLOMEW COUNTY

Bartholomew County Home (R)
2525 Illinois, Columbus 47201
Mildred Drake, Adm.

Columbus Convalescent Center (C)
2100 Midway St., Columbus 47201
Elizabeth Kerns, Adm.

Columbus Nursing Home (C)
5400 E. 25th Street, Columbus 47201
Janet L. Johnson, Adm.

The Four Seasons Home (R&C)
1901 Taylor Road, Columbus 47201
John Schenck, Adm.

Ken-Joy Convalescent Home (C)
133 Maple Street, Hope 47246
Betty P. Beck, Adm.

Lake View Care Center, Inc. (R&C)
R. R. 1, Hope 47246
David Eisele, Adm.

BENTON COUNTY

Earl Park Nursing Home (C)
400 Chestnut, Earl Park 47942
Evelyn Taylor, Adm.

Edgewood View (C)
State Road #55, Oxford 47971
Doris J. Brazzell, R.N., Adm.

Green-Hill Manor, Inc. (C)
501 N. Lincoln Ave., Fowler 47944
Edith Dexter, R.N. and Connie
Brouillette, R.N., Adms.

BLACKFORD COUNTY

Country Manor Nursing Home (C)
R. R. 2, Box 53A, Hartford City 47348
Janellyn Antrim, R.N., Adm.

Hartford City Community Care Center (C)
715 N. Mill St., Hartford City 47348
Steven P. Haggerty, Adm.

BOONE COUNTY

English Nursing Home, Inc. (C)
1015 N. Lebanon St., Lebanon 46052
Frank H. English, Adm.

The Hoosier Village (R&C)
5300 W. 96th St., Indianapolis 46268
Robert A. DeVoss, Adm.

Lebanon Nursing Home (C)
301 W. Essex, Lebanon 46052
Robyn Sams, Adm.

Oak Park Manor (C)
R. R. #2, Lebanon 46052
Margaret E. Hine, Adm.

CARROLL COUNTY

Brethren's Home of Indiana, Inc. (C)
R. R. 2, Flora 46929
Rosemary Eddy, Adm.

Delphi Nursing Home (C)
1455 S. Washington St., Delphi 46923
Helen McDonald, Adm.

CASS COUNTY

Camelot Care Center (C)
1555 Commerce St., Logansport 46947
Dorothy Huston, Adm.

Cass County Home (R)
Perrysburg Rd., Logansport 46947
Mabel Frey, Adm.

Chase Manor Nursing and Convalescent Center (R&C)
1 Chase Park, Logansport 46947
Rob James, Adm.

The Neal Home (BHA)
2518 George St., Logansport 46947
Mary A. Curless, Adm.

CLARK COUNTY

Hillcrest Nursing Home, Inc. (C)
203 Sparks Ave., Jeffersonville 47130
Lee Roy E. Martin, Adm.

Jeffersonville Nursing Home (C)
1720 E. Eighth St., Jeffersonville 47130
Patricia Ragland, L.P.N., Adm.

Kentuckiana Christian Home, Inc. (R&C)
Route 2, Box 39, Charlestown 47111
Stanley Hunt, Adm.

The Ladies Home, Inc. (R)
330 W. Market St., Jeffersonville 47130
Helen Haynes, Adm.

Maple Manor Christian Home, Inc.—Adult Division (R&C)
643 W. Utica, Sellersburg 47172
Joe Blansett, Adm.

Tendercare/Clarksville (C)
517 N. Hallmark Dr., Clarksville 47130
Ruth M. Rinkhoff, R.N., Adm.

Turtle Creek Convalescent Centre—Clarksville (C)
286 Eastern Blvd., Clarksville 47130
Phoebe Hall, Adm.

Twilight Nursing Home, Inc. (C)
418 W. Riverside Dr., Jeffersonville 47130
Delilah J. Swaney, Adm.

CLAY COUNTY

Clay County Health Center, Inc. (C)
1408 E. Hendrix Street, Brazil 47834
Wilma Ellison, Adm.

Harty Nursing Home (C)
P. O. Box 112, Knightsville 47857
William E. Harty, Adm.

Macanell Nursing Home, Inc. (C)
R. R. 2, Box 139, Center Point 47840
Hugh W. McCann, Adm.

Stinson Nursing Home, Inc. (C)
601 S. Leavitt St., Brazil 47834
Madge Scobell, Adm.

CLINTON COUNTY

Clinton Convalescent Center, Inc. (C)
551 E. Walnut St., Frankfort 46041
Laura L. Peterson, Adm.

Frankfort Nursing Home (C)
1234 Rossville Ave., Frankfort 46041
Carolyn Dulin, Adm.

Milner Community Health-Care, Inc. (C)
Box 15, Rossville 46065
Ronald C. Green, Adm.
Mulberry Lutheran Home, Inc. (R&C)
State Route 38, W. Jackson St.,
Mulberry 46058
Rev. Paul Mumford, Adm.

Parkview Home (R)
R. R. 2, Frankfort 46041
Dorothy M. Schriefer, L.P.N., Adm.

Wesley Manor, Northwest Indiana Methodist Home, Inc. (R&C)
1555 N. Main St., Frankfort 46041
Rev. Glenn Copeland, Adm.

DAVISS COUNTY

Bertha D. Garten Ketcham Memorial Center, Inc. (C)
601 E. Race Street, Odon 47562
Homer E. Robertson, Adm.

Eastgate Manor Nursing and Residential Center, Inc. (R&C)
P. O. Box 470, Highway 50 East,
Washington 47501
Larry N. Morris, Adm.

Prairie Village, Inc. (C)
1401 Highway 57, South, Washington 47501
Georgia Atwood, Adm.

Shady Heights Nursing Home (C)
1109 E. National Highway,
Washington 47501
Mrs. Cecil Shurbett, L.P.N., Adm.

Washington Nursing Center, Inc. (C)
603 E. National Highway,
Washington 47501
David L. Snow, Adm.

Washington Nursing Center Annex (C)
215 W. Oak St., Washington 47501
Jerome Walker, Adm.

DEARBORN COUNTY

Dillsboro Manor (R&C)
Box 66, Dillsboro 47018
Dellas and Dortha Ross, Adms.

Shady Nook Convalescent Home (C)
607 Wilson Creek Rd., Lawrenceburg 47025
Wilbur & Margaret McMullen, Adms.

Terrace View ECF (C)
403 Bielby Rd., Lawrenceburg 47025
Joseph Henderson, Adm.

DECATUR COUNTY

Greensburg Hospitality Nursing Center, Inc. (C)
410 Park Road, Greensburg 47240
Willard Rowland, L.P.N., Adm.

Greensburg Nursing Home (C)
1420 Lincoln St., Greensburg 47240
James Thurston, R.N., Adm.

Odd Fellows Home (R&C)
R. R. 8, Greensburg 47240
Thomas A. Baldus, Adm.

DEKALB COUNTY

Betz Residential Home (R)
R.R. 3, Auburn 46706
Doris M. Betz, L.P.N., Adm.

Betz Nursing Home (C)
R. R. 3, Auburn 46706
Doris M. Betz, L.P.N., Adm.

Butler Hotel Rest Home, Inc. (C)
117 S. Broadway St., Butler 46721
David Davenport, Adm.

Glen Oaks Nursing Home (C)
E. Seventh St., St. Rd. 8, Auburn 46706
Thomas Muzzillo, Adm.

Meadowhaven, Inc. (C)
300 West Liberty, Butler 46721
Dallas Winn, Adm.

Souder Health Care (C)
206 W. 7th St., Auburn 46706
Ruth Muzzillo, Adm.

DELAWARE COUNTY

Albany Nursing Care, Inc. (C)
State Rd 67 North, Albany 47320
Nicholas LeFevre, Adm.

Chateau Convalescent Centre (C)
2400 Chateau Drive, Muncie 47303
Lowell Canary, Jr., Adm.

Delaware County Home (R&C)
R. R. 5, Box 157, Muncie 47302
Helen V. Stewart, Adm.

**Friendly Hearth Nursing Center of
Muncie, Inc. (C)**
633 N. Gavin St., Muncie 47302
Anna Slusher, Adm.

Golden Rule Nursing Home (C)
502 N. Madison Ave., Gaston 47342
David Boston, Adm.

Maple Grove Convalescent Home (C)
1347 East Jackson St., Muncie 47302
Deirdree Ann Harty, Adm.

Parkview Nursing Home (C)
2200 White River Blvd., Muncie 47303
Eileen E. Page, R.N., Adm.

Riverview Convalescent Home (C)
R. R. 2, Box 89, Muncie 47302
Jessie Starks, L.P.N., Adm.

Sylvester Home for the Aged (C)
R. R. 2, Burlington Dr., Muncie 47302
Mantha J. Sylvester, Adm.

Westminster Village Muncie (BHA&C)
5601 Bethel Pike, Muncie 47302
Allen Jump, Adm.

Woodland Nursing Home (C)
3600 W. Jackson St., Muncie 47304
Hazel Wilson, R.N., Adm.

DUBOIS COUNTY

Jasper Nursing Center, Inc. (C)
2909 Howard Dr., Jasper 47546
John L. Wehrle, Adm.

Medco Center of Huntingburg (C)
530 Fourth St., Huntingburg 47542
Joan Massengill, Adm.

Northwood Good Samaritan Center (C)
P. O. Box 459, Jasper 47546
Richard E. Faught, Adm.

Providence Home (R)
520 W. Ninth Street, Jasper 47546
Father Thaddeus Sztuczko, F.D.P., Adm.

ELKHART COUNTY

**Americana Healthcare Center of Elkhart
(C)**
343 S. Nappanee St., Elkhart 46514
Arthur Hodde, Adm.

Fountainview Place (R&C)
1001 W. Hively Ave., Elkhart 46514
John M. Kolb, Adm.

Fountainview Place of Goshen (R&C)
2400 College Ave., Goshen 46526
Arlette Young, Adm.

Goshen Nursing Home (C)
1101 W. Lincoln Ave., Goshen 46526
Alice Rees, Adm.

Greencroft Nursing Center (C)
2000 South 15th St., Goshen 46526
John Liechty, Adm.

Lu-Ann Nursing Home (C)
952 W. Walnut St., Nappanee 46550
John L. Mellinger Adm.

Medco Center of Elkhart (C)
2600 Morehouse Ave., Elkhart 46514
Paul Ward, Adm.

**Turtle Creek Convalescent Centre of
Elkhart (C)**
1400 W. Franklin St., Elkhart 46514
James Scheller, Adm.

FAYETTE COUNTY

Connersville Care Center (C)
2500 Iowa St., Connersville 47331
Roberta K. Caldwell, Adm.

Connersville Nursing Home (C)
2600 N. Grand Ave., Connersville 47331
Fred Stubbs, Adm.

Lincoln Manor Nursing Center (C)
1029 E. Fifth St., Connersville 47331
Chester O'Neal, Jr., Adm.

FLOYD COUNTY

Green Valley Convalescent Center (C)
3118 Green Valley Rd., New Albany
47150
Peter Graves, Adm.

Lincoln Hills of New Albany (C)
326 Country Club Dr., New Albany
47150
Paul A. Ferry, Jr., Adm.

New Albany Nursing Home (C)
1919 Bono Road, New Albany 47150
Neil Johnson, Adm.

Providence Retirement Home (R&C)
703 E. Spring St., New Albany 47150
Sister Mary Loyola Bender, S.P. Adm.

FOUNTAIN COUNTY

Covington Manor, Inc. (C)
1600 Liberty St., E. Covington 47932
William C. Button, Jr., Adm.

Woodland Manor Nursing Center (C)
P.O. Box 166, Attica 47918
Linda L. Short, Adm.

FRANKLIN COUNTY

Elsie Dreyer Nursing Home (C)
273 Main St., Brookville 47012
Melvin Brunner, Adm.

FULTON COUNTY

Canterbury Manor (C)
R. R. 6, County Road 50
North, Rochester 46975
Carl William Miller II, Adm.

Rochester Nursing Home (C)
240 E. 18th St., Rochester 46975
Leona Watts, Adm.

GIBSON COUNTY

Forest Del Convalescent Home Inc. (C)
1020 W. Vine St., Princeton 47570
Kenneth Maikranz, Adm.

Good Samaritan Home Inc. (C)
210 N. Gibson St., Oakland City 47560
Hovey Hedges & Donald Bogan, Adms.

Holiday Manor, Inc. (C)
305 Carol Ave., Princeton 47570
Larry D. Carlson, Adm.

Oakland City Rest Home (C)
114 Grove St., Oakland City 47560
Lloyd Higgins, Adm.

Owensville Convalescent Center (C)
Highway 165, P. O. Box 368
Owensville 47565
Harold J. Baker and Ruth A. Braselton,
Adms.

GRANT COUNTY

**Bradner Village Residential Care
Facility, Inc. (BHA, R&C)**
505 Bradner Ave., Marion 46952
James J. Walts, Adm.

Emily E. Flinn Home, Inc. (R&C)
615 W. 12th St., Marion 46952
Rev. George L. Florence, Adm.

Golden Age Nursing Home (C)
1800 Kem Rd., Marion 46952
Rebecca McPherson, Adm.

River-View Manor Nursing Home (C)
221 N. Washington, Marion 46952
Sharon Myers, Adm.

Twin City Nursing Home (C)
627 East-North "H" St., Gas City 46933
Margaret Knox, Adm.

University Nursing Center (C)
University Avenue, Upland 46989
Margaret J. Crick, Adm.

Wesleyan Nursing Home (C)
518 W. 36th St., Marion 46952
E. Barton Carter, Adm.

GREENE COUNTY

Bloomfield Nursing Center (C)
150 N. Seminary St., Bloomfield 47424
Norman Nierste, Adm.

Glenburn Rest Haven Home (C)
Glenburn Rd., R. R. 2, Linton 47441
William Thomas Fisher, Adm.

Linton Nursing Home (C)
1501 East A Street, Linton 47441
Milford Stone, Adm.

Shakamak Good Samaritan Center (C)
800 E. Ohio, Box 163, Jasonville 47438
Rev. Howard N. Larsen, Adm.

HAMILTON COUNTY

Arcadia Children's Home (C)
303 Franklin Ave. Arcadia 46030
Leonard A. Hall, Adm.

**Cardinal Care Centers of Westfield, Inc.
(C)**
R. R. 2, Box 700, Westfield 46074
Lowell Canary, Jr., Adm.

Hamilton Heights Health Center (C)
706 W. Main St.
Arcadia 46030
Lester M. Roland, Adm.

Lakeview Nursing Facility (C)
2907 E. 136th St., Carmel 46032
Paul D. Walters, Adm.

Noblesville Nursing Home (C)
1391 Greenfield Pike, Noblesville 46060
Patricia Jarvis, R.N., Adm.

Rollins Home for Retarded Children (C)
69 N. Harrison St., Cicero 46034
Jane G. Fenn, Adm.

Sheridan Rest Home, Inc. (C)
903 Sheridan Ave., Sheridan 46069
Hal G. Higgins, Adm.

**Turtle Creek Convalescent Centre-
Noblesville (C)**
295 Westfield Rd., Noblesville 46060
Mary Ann Geer, Adm.

Watson Nursing Home for Children (C)
Route #1, Cicero 46034
Vivian Beam, Adm.

HANCOCK COUNTY

Beeson's Nursing Home (C)
R.R. 8, Box 470, Greenfield 46140
Lavon Beeson, Adm.

**Colonial Crest Convalescent Center, Inc.
(C)**
745 N. Swope St., Greenfield 46140
Mark Hasten, Adm.

Crescent Manor Nursing Home (C)
1310 E. Main St., Greenfield 46140
Gwendolyn Suttle, R.N., Adm.

Golden Rule Rest Home (C)
R. R. 12, Box 403, Indianapolis 46236
Bernard H. Beck, Adm.

Twinbrook, Inc. (C)
R. R. 7, Box 70, Greenfield 46140
Kenneth R. Smith, Adm.

HARRISON COUNTY

Corydon Nursing Home (C)
Route 6, Box 147, Corydon 47112
David M. Ragland, Adm.

HENDRICKS COUNTY

Danville Nursing Home (C)
337 W. Lincoln St., Danville 46122
Susan Runyan, R.N., Adm.

Golden Manor Health Care Center (C)
Hornaday Rd., Brownsburg 46112
James R. Gephart, Adm.

Golden Rule Nursing Home (C)
St. Rd. #36 and 400 East
Danville 46122
Robert Petree, Adm.

Hendricks County Home (R)
865 E. Main, Danville 46122
Edna O. Anderson, Adm.

Tendercare/Danville (C)
255 Meadow Drive, Danville 46122
Robert F. Weddle, Adm.

Vinewood Nursing Home, Inc. (C)
404 North Vine St., Plainfield 46168
Mary Lou Ingle, Adm.

HENRY COUNTY

**Heritage House, Inc., of New Castle,
Indiana (C)**
P.O. Box 546, New Castle 47362
Robert W. Dorsett, Adm.

Holly Hill Nursing Home (C)
901 N. 16th St., New Castle 47362
Giles Krupp, Adm.

Lewisville Hotel for Senior Citizens (R)
Box 98, U. S. 40, Lewisville 47352
Sarah E. Vollmer, Adm.

Maple Village Nursing Home, Inc. (C)
Box 135, Middletown 47356
F. Richard King, Adm.

Middletown Nursing Center (C)
130 S. 10th St., Middletown 47356
Larry A. Jones, Adm.

New Castle Community Care Center (C)
115 N. 10th Street, New Castle 47362
Donald Weaver, Adm.

New Hope Nursing Home (C)
Lewisville 47352
Robert Baird, Adm.

**Turtle Creek Convalescent Centre of
New Castle (C)**
990 North 16th St., New Castle 47362
Timothy J. DeBruicker, Adm.

HOWARD COUNTY

**Americana HealthCare Center of
Kokomo (C)**
3518 S. Lafountain St., Kokomo 46901
Leroy Policky, Adm.

Kokomo Nursing Home (C)
1560 S. Plate St., Kokomo 46901
Linda Crowe, L.P.N., Adm.

Sycamore Village Health Center (C)
2905 W. Sycamore, Kokomo 46901
John Singleton, Adm.

Turtle Creek Convalescent Center of Kokomo (C)
2233 W. Jefferson, Kokomo 46901
Ruth Brockman, Adm.

Windsor Estates of Kokomo (C)
429 Lincoln Rd. W., Kokomo 46901
Ms. Donna Scott, Adm.

HUNTINGTON COUNTY

Huntington Nursing Home (C)
1425 Grant St., Huntington 46750
Virginia Griggs, R.N., Adm.

Miller's Merry Manor, Inc. (C)
1500 Grant St., Huntington 46750
James L. Powell, Adm.

Norwood Nursing Center (C)
R.R. 8, Maple Grove Rd., Huntington 46750
Mark A. Matiukas, Adm.

United Methodist Memorial Home (R&C)
Warren 46792
Philip Souder, Adm.

JACKSON COUNTY

Jackson Park Convalescent Center, Inc. (C)
707 Jackson Park Dr., Seymour 47274
Richard C. Schriever, Adm.

Lutheran Community Home, Inc. (C)
111 W. Church Ave., Seymour 47274
George Risch, Adm.

R & S Nursing Center, Inc. (C)
202 W. Sixth St., Seymour 47274
Roger A. Russell, Adm.

JASPER COUNTY

Rensselaer Care Center (C)
Highway 114 East, Rensselaer 47978
Larry Lee Vanderwielen, Adm.

JAY COUNTY

Country Manor Nursing Home, Inc. (C)
Route 2, Dunkirk 47336
Richard T. Antrim, Adm.

Portland Community Care Center (C)
200 N. Park St., Portland 47371
Dixie May, Adm.

Portland Nursing Home (C)
406 W. Arch St., Portland 47371
Mary Ellen Hearn, Adm.

JEFFERSON COUNTY

Clifty Falls Convalescent Center (C)
950 Cross Ave., Madison 47250
Ailene Breitenbach, Adm.

Hanover Nursing Center (C)
S. R. 56 W., Hanover 47243
Ann Breitenbach, R.N., Adm.

Madison Nursing Home (C)
1945 Cragmont St., Madison 47250
Mary Snodgrass, Adm.

Mayfield Nursing Home (C)
702-710 Elm St., Madison 47250
Susan Williamson, Asst. Adm.

JENNINGS COUNTY

North Vernon Nursing Home (C)
801 N. Elm Street, North Vernon 47265
Peggy Watson, L.P.N., Adm.

JOHNSON COUNTY

Faith Home (C)
P. O. Box 218, Edinburg 46124
Raymond C. Brown, Adm.

Franklin Healthcare Centre, Inc.
Route 1, Franklin 46131
James R. Haas, Adm.

Franklin Nursing Home (C)
1130 N. Main St., Franklin 46131
Mary L. Johnson, Adm.

Franklin United Methodist Home (R&C)
1070 W. Jefferson, Franklin 46131
Norman E. Amtower, Adm.

Homeview Convalescent Center (C)
651 S. State St., Franklin 46131
Nadine Weaver, Adm.

Indiana Masonic Home (R)
Old State Road 31, Franklin 46131
Marvin Isley, Adm.

We Care Health Center-Greenwood, Inc. (C)
937 Fry Road, Greenwood 46142
Thelma Richardson, L.P.N., Adm.

The Welcome Nursing Home (C)
1109 N. Main St., Franklin 46131
Alida Van Biezen, Adm.

Westminster Village (R&C)
U.S. 31 South, Greenwood 46142
A. Leon Smith, Adm.

KNOX COUNTY

Beverly Manor Convalescent Center (C)
1321 Willow St., Vincennes 47591
Marge Morris, Adm.

Crestview Convalescent Home (C)
Box 136, Old Bruceville Rd., Vincennes 47591
Joy M. Thornberry, R.N., Adm.

Freelandville Community Home, Inc. (C)
Highway #58, Freelandville 47535
Mary Jane Buescher, Adm.

Moore's Nursing Home, Inc. (C)
204 W. Third St., Bicknell 47512
Ernest P. and Barbara J. Moore, Adms.

Vincennes Nursing Home, Inc. (C)
1202 S. 16th St., Vincennes 47591
Joe Junod Jr., Adm.

KOSCIUSKO COUNTY

Alfran Nursing Home (C)
2501 E. Center St., Warsaw 46580
Frank N. Wilson, Adm.

Miller's Merry Manor, Inc. (R&C)
P. O. Box 387, County Farm Rd., Warsaw 46580
R. James Miller, Adm.

Orn Nursing Home (C)
P.O. Box 308, North Main St., Milford 46542
Glennis Stump and Elizabeth Steinke, Adms.

Prairie View Rest Home, Inc. (C)
300 Prairie St., Warsaw 46580
N. Charlene Bradbury, Adm.

Warsaw Nursing Home (C)
2402 E. Center St., Warsaw 46580
Wilma T. Davenport, R.N., Adm.

LAGRANGE COUNTY

Lagrange Nursing Home (C)
Town Line Rd. & North St., LaGrange 46761
Charles Bellus, Adm.

Miller's Merry Manor, Inc. (C)
State Road 9 North, LaGrange 46761
Phyllis Ann Miller, Adm.

LAKE COUNTY

Colonial House, Inc. (C)
119 N. Indiana Ave., Crown Point 46307
Laura M. Gumbiner, Adm.

East Chicago Rehabilitation and Convalescent Center, Inc. (C)
5025 McCook Ave., East Chicago 47312
Jerry H. Henderson, Jr., D.D.S., Adm.

Fountain View Manor (C)
2901 W. 37th Ave., Hobart 46342
Carl Raskin, Adm.

Fuchs' Nursing Home, Inc. (C)
255 Burnham St., Lowell 46356
Barbara H. and Phyllis Fuchs, Adms.

Gary Convalescent Home, Inc. (C)
386 Mount St., Gary 46406
Joseph Fertel, Adm.

Green's Geriatric Health Center (C)
2052 Delaware St., Gary 46407
Benjamin J. Green, Adm.

Hammond Nursing Home (C)
1402 E. 173rd St., Hammond 46320
Robert Graves, Adm.

Hammond-Whiting Convalescent Center (C)
1000—114th St., Whiting 46394
Cheryl E. Diamond, Adm.

Highland Nursing Home (C)
9630 Fifth St., Highland 46322
Radmilla Bogdanich, Adm.

Lake County Convalescent Home (C)
2900 W. 93rd Ave., Crown Point 46307
Dorothy Gaski, Adm.

Miller Nursing Home, Inc. (C)
2301 Adams St., Gary 46407
Ida Miller Walker, Adm.

Mills Rest Home (C)
5011 Maryland St., Gary 46409
David L. Mills, Adm.

Munster Med-Inn (C)
7935 Calumet Ave., Munster 46321
Jean Robinson, Adm.

Ross Care Center (C)
601 W. 61st Ave., Merrillville 46410
Reginald E. Brown, Jr., Adm.

St. Ann's Home (R)
5927 Columbia Ave., Hammond 46320
Arthur W. March, Adm.

St. Anthony's Rest Home (R&C)
201 Franciscan Rd., Crown Point 46307
Lawrence T. Filosa, Adm.

Sebo Heritage Manor Nursing Home (C)
4410 W. 49th Ave., Hobart 46342
Wanda Sebo, Adm.

Simmons Loving Care Health Facility (C)
700 E. 21st Ave., Gary 46407
Anna L. Simmons and Herberta B. Miller
Adms.

West Side Nursing Home (C)
353 Tyler St., Gary 46402
Gerald Rothenberg, Adm.

Wildwood Manor, Inc. (C)
1964 Clark Rd., Gary 46404
Doris Williams, Adm.

LAPORTE COUNTY

Beach Cliff Lodge Nursing Home (C)
1001 Lake Shore Dr., Michigan City
46360
Janice Brown, R.N., Adm.

The Countryside Place (C)
1700 "I" St., LaPorte 46350
LuAnn Nebelung, Adm.

Fountainview Terrace (R&C)
1900 Andrew Ave., LaPorte 46350
Edward Kuc, Adm.

Lakeside Health Center, Inc. (C)
802 Highway 20, East, Michigan City
46360
Donald G. Cowen, Adm.

Red Oaks Home (C)
910 S. Carroll Ave., Michigan City
46360
Maryann Oszusick, R.N., Adm.

Wedow Private Home Care (R)
602 Spring St., Michigan City 46360
Wilbur Wedow, Adm.

Woodview Rehabilitation Center (C)
1101 E. Coolspring Ave.
Michigan City 46360
Frank Estes, Adm.

LAWRENCE COUNTY

Bedford Nursing Home (C)
514 E. 16th St., Bedford 47421
Nellie M. Camp, Adm.

Hospitality House (C)
2122 Norton Lane, Bedford 47421
Maribelle S. Dyer, Adm.

Mitchell Manor (C)
Hwy. 37 & 60, Mitchell 47446
Mary Williams, Adm.

NHE/Bedford (C)
1510 Clinic Drive, Bedford 47421
Marilyn Johnson, Adm.

MADISON COUNTY

Americana Nursing Center of Anderson (C)
1345 N. Madison Ave., Anderson 46011
A. Wayne Johnson, Adm.

Bradford Nursing Home (R&C)
625 W. Adams St., Alexandria 46001
Mary Ellen Bell, Adm.

Convalescent Centre of Anderson, Inc. (C)
1809 N. Madison Ave., Anderson 46012
M. Kent Stephens, Adm.

Dickey Nursing Home, Inc. (C)
1007 N. 9th, Elwood 46036
Louise Dickey, L.P.N., Adm.

The Goble Home (R&C)
332 W. 11th St., Anderson 46016
Dillard Marcum, Adm.

New Haven Nursing Home (C)
1023 E. Eighth St., Anderson 46012
Josephine Wade, L.P.N., Adm.

Parkview Convalescent Center (C)
North 19th St., Elwood 46036
Rev. Max Bingham, Adm.

Rolling Hills Convalescent Center, Inc. (C)
1821 Lindberg Rd., Anderson 46012
Harold Thompson, Adm.

Summit Convalescent Center, Inc. (C)
R. R. 1, Summitville 46070
Richard Goodman, Adm.

The Willows (C)
R. R. 2, Box 514C, Alexandria 46001
Marian E. Webb, L.P.N., Adm.

MARION COUNTY

Ada's Golden Age, Inc. (C)
2115 Central Ave., Indianapolis 46202
Keith F. Seal, Adm.

The Alpha Home (C)
1910 N. Senate Ave., Indianapolis 46202
Emarita Murphy, Adm.

The Altenheim Community United Church Homes, Inc. (BHA, C)
3525 E. Hanna, Indianapolis 46227
Robert Frey, Adm.

Americana Health Care Center of Indianapolis—Midtown (C)
2010 N. Capitol Ave., Indianapolis
46202
David C. Winters, Adm.

Americana Nursing Center of Indianapolis—East (C)
5600 E. 16th St., Indianapolis 46218
Fred Moon, Adm.

Americana Healthcare Center of Indianapolis—North (R&C)
8350 Naab Road, Indianapolis 46260
Gerald W. McGowan, Adm.

Anthony Hall Nursing Home, Inc. (C)
2135 N. Alabama St., Indianapolis
46202
Winston Hunter, Adm.

The Barton House (C)
505 N. Delaware, Indianapolis 46204
Audrey Bonner, Adm.

Bel-Terrace Nursing Home, Inc. (C)
1629-33 N. College Ave., Indianapolis
46202
Thelma Wray, L.P.N., Adm.

- Booker Watts Nursing Home (C)**
2523 Central, Indianapolis 46205
Herbert Watts, Adm.
- Broad Ripple Nursing Home (C)**
6127 N. College Ave.
Indianapolis 46220
Josephine Lauth, Adm.
- Chateau de Repos, Inc. (C)**
5025 W. 52nd St., Indianapolis 46254
Doris E. Stuart, L.P.N., Adm.
- Colonial Crest Convalescent Center, 86th St. (C)**
2002 W. 86th St., Indianapolis 46260
William Myers, Adm.
- Colonial Crest Convalescent Center-North (C)**
8181 Harcourt Road, Indianapolis 46260
Stephen Harris, Adm.
- Colonial Crest Convalescent Center South (C)**
2860 Churchman Ave.
Indianapolis 46203
Margaret Hawkins, Adm.
- Colonial Crest Nursing Center, Inc. (C)**
7145 E. 21st St., Indianapolis 46219
Thomas W. Stader, Adm.
- Community Children's Nursing Home (C)**
6855 E. 10th St., Indianapolis 46219
Joseph Baldus, Adm.
- Continental Convalescent Center (C)**
344 S. Ritter, Indianapolis 46219
Arthur J. Mirkin, Adm.
- Crestview Manor Nursing Home (C)**
1118 East 46th St., Indianapolis 46205
Margaret Cronin, Adm.
- Dailey's Convalescent Home, Inc. (C)**
2926 N. Capitol Ave., Indianapolis 46208
Anderson T. Dailey, Adm.
- Delaware Nursing Home (C)**
1910 N. Delaware, Indianapolis 46202
Veda Y. Powell, Adm.
- Del Mar Nursing Home, Inc. (C)**
709 S. Lynhurst Dr., Indianapolis 46224
Helen J. Harbison, Adm.
- Emerson Nursing Home (C)**
3420 N. Emerson Ave., Indianapolis 46218
William Medley, Adm.
- Evangelistic Center, Inc. (R&C)**
3518 Shelby St., Indianapolis 46227
Roger T. Qualls, Adm.
- Fairfield Nursing Home (C)**
3630 Central, Indianapolis 46205
Mary L. Fitzsimmons, Adm.
- Fountainview Place of Indianapolis (R&C)**
5353 E. Raymond, Indianapolis 46203
Jeremy D. Carter, Adm.
- Frame Nursing Home, Inc. (C)**
373 N. Holmes Ave., Indianapolis 46222
James R. McCarroll, Adm.
- Garfield Park Nursing Home (C)**
2630 S. Keystone, Indianapolis 46203
Wanda L. Dixon, Adm.
- Greenview Manor, Inc. (C)**
1700 N. Illinois St., Indianapolis 46202
James B. Snavley, Adm.
- Hillside Nursing Home (C)**
3405 N. Ralston, Indianapolis 46218
Leonard Scott, D.D.S., & Bernice Scott, Adms.
- Hooverwood (C)**
7001 Hoover Rd., Indianapolis 46260
Lazer D. Brener, Adm.
- Independent Living Club (BHA)**
6038 W. 25th St., Indianapolis 46224
Robert Roland, Adm.
- Indianapolis Retirement Home (R&C)**
1731 N. Capitol Ave., Indianapolis 46202
Betty Sell, R.N., Adm.
- Lakeview Manor, Inc. (C)**
45 Beachway Dr., Indianapolis 46224
Thomas F. Tyson, Jr., Adm.
- Lawrence Manor Nursing Home (C)**
8935 E. 46th St., Indianapolis 46226
Mark Feeser, Adm.
- Lynhurst Nursing Home, Inc. (R&C)**
5225 W. Morris St., Indianapolis 46241
James E. Hill, Sr., Adm.
- Mapleton Nursing Home**
3650 Central Ave., Indianapolis 46205
Helen Harris, Adm.
- Marion County Home (R&C)**
11850 Brookville Rd., Indianapolis 46239
Henry H. Bahner, Adm.
- Mayfair Home (R)**
3240 Washington Blvd., Indianapolis 46205
Joseph Ewbank, Adm.
- Meridian Nursing Home (C)**
2102 S. Meridian Street, Indianapolis 46225
Neville Humphrey, Adm.
- Northwest Manor Nursing Home (C)**
6440 West 34th St., Indianapolis 46224
Jennifer A. Knoll, R.N., Adm.
- Parkview Manor Nursing Home (C)**
2424 E. 46th St., Indianapolis 46205
Albert Harris, Jr., Adm.
- Riley Nursing Home (C)**
901 N. East St., Indianapolis 46202
Doris Loudermilk, Adm.
- Rural Nursing Home (C)**
1747 N. Rural, Indianapolis 46218
Marilyn Conner, L.P.N., Adm.
- St. Augustine Home for the Aged (R&C)**
2345 W. 86th St., Indianapolis 46260
Sister Stephen Marie Cronin, Adm.
- St. Paul Baptist Church Home for the Aged (C)**
1141-45 N. Sheffield Ave., Indianapolis 46222
Anna Dailey, Adm.
- St. Paul Hermitage (R&C)**
501 N. 17th St., Beech Grove 46107
Sister Mary Gilbert Schipp, O.S.B., Adm.
- Sarah's Nursing Home (C)**
3208 N. Sherman Dr., Indianapolis 46218
Dorothy Morrison, Adm.
- Southeastern Nursing Home (C)**
4743 Southeastern Ave., Indianapolis 46203
E. Lucile Smith, L.P.N., Adm.
- Stone Manor Convalescent Home (C)**
8201 W. Washington St., Indianapolis 46231
Sue Carter, Adm.
- Three Sisters Nursing Home, Inc. (C)**
6130 Michigan Rd., Indianapolis 46208
Mamie Beamon, Adm.
- Turtle Creek Convalescent Centre—East, Inc. (C)**
1302 N. Lesley Ave., Indianapolis 46219
Steven Minnear, Adm.
- Turtle Creek Convalescent Centre, Central, Inc. (R&C)**
55 West 33rd St., Indianapolis 46208
Benton Harlan, Adm.
- Turtle Creek Convalescent Centre, Ritter (C)**
1301 N. Ritter, Indianapolis 46219
Edwin R. Wright, Adm.
- Turtle Creek Convalescent Centre North, Inc. (C)**
2140 W. 86th St., Indianapolis 46260
Richard Lewis, Adm.
- Turtle Creek Convalescent Centre—South (C)**
525 E. Thompson Rd., Indianapolis 46227
Rosemary Lain, Adm.
- Turtle Creek Convalescent Centre Southeast, Inc. (C)**
2002 Albany Ave., Beech Grove 46107
Paul C. Ade, Adm.

Warren Park Nursing Home (C)
6855 E. 10th, Indianapolis 46219
Lenvil Hall, Adm.

Westminster Village North Health Center (C)
11050 Presbyterian Dr., Indianapolis 46236
Wanda Herzog, Adm.

Westview Nursing Home (C)
5435 West 38th St., Indianapolis 46224
John Jennings, Adm.

MARSHALL COUNTY

Kingston Nursing Home (C)
309 Kingston Drive, Plymouth 46563
James Drews, R.N., Adm.

Miller's Merry Manor, Inc. (C)
600 W. Oakhill Ave., Plymouth 46563
Jane K. Miller, R.N., Adm.

Myers Nursing Home, Inc. (C)
R. R. 3, Box 159, Bremen 46506
Pauline Studt, Adm.

Pilgrim Manor Rehabilitation and Convalescent Center (C)
222 Parkview St., Plymouth 46563
G. Dean Byers, Adm.

R.N. Nursing Home (C)
R. R. 1, Walkerton 46574
Laura M. Hathaway, R.N., Adm.

Shady Rest Home (R)
R. R. 5, Plymouth 46563
Kathryn Krueger, Adm.

MARTIN COUNTY

Medco Center of Loogootee (C)
R. R. 4, Loogootee 47553
Mary Lee Wildman, Adm.

MIAMI COUNTY

Miller's Merry Manor, Inc. (R&C)
317 Blair Pike, Peru 46970
Alan Grossnickle, Adm.

Peru Nursing Home (C)
390 West Blvd., Peru 46970
Daniel W. Woods, Adm.

MONROE COUNTY

Bloomington Convalescent Center (C)
714 S. Rogers St., Bloomington 47401
Mr. Carroll Moore, Adm.

Bloomington Nursing Home (C)
120 E. Miller Dr., Bloomington 47401
William Doub, Adm.

Fontanbleu Nursing Center (C)
3305 South Highway 37, Bloomington 47401
J. L. Huffer, Adm.

Hospitality House, Inc. (R&C)
1100 S. Curry Pike, Bloomington 47401
Fred J. Ponton, Adm.

MONTGOMERY COUNTY

Ben Hur Home, Inc. (C)
1375 S. Grant, Crawfordsville 47933
Esther Houston, Adm.

Carmen Nursing Home (C)
817 N. Whitlock Ave., Crawfordsville 47933
Cline Harbison, Adm.

Golden Manor Health Care Center (C)
1001 E. Main St., Ladoga 47954
Opal I. Gephart, Adm.

Lane House, Inc. (C)
1000 Lane Ave., Crawfordsville 47933
Richard A. Bowles, L.P.N., Adm.

MORGAN COUNTY

Cherry Nursing Home (C)
60 E. Harrison St., Martinsville 46151
William Keith, Adm.

Countryaire Manor, Inc. (C)
259 W. Harrison St., Mooresville 46158
Larry E. Gray, Adm.

Grand View Nursing Home (C)
2009 E. Columbus St., Martinsville 46151
Myrtle Rynard, Adm.

Henderson Nursing Home, Inc. (C)
140 W. Washington St., Morgantown 46160
E. Marguerite Henderson, Adm.

Kennedy Memorial Christian Home (R&C)
210 W. Pike St., Martinsville 46151
W. Dean Mason, Ed.D., Adm.

NEWTON COUNTY

Kentland Kare Home (C)
102 E. Carroll St., Kentland 47591
Helen M. Borman, R.N., & Eric Borman, Adms.

Kentland Nursing Home (C)
720 E. Washington St., Kentland 47591
Marguerite Boerger, Adm.

NOBLE COUNTY

Kendallville Nursing Home (C)
1433 S. Main St., Kendallville 46755
Byron Colglazier, Adm.

Linville Boarding Home (BHA)
518 E. Diamond, Kendallville 46755
Weltha Linville, Adm.

Lutheran Homes, Inc. (R&C)
612 E. Mitchell, Kendallville 46755
Paul Dobler, Adm.

Sacred Heart Home (R&C)
R. R. 2, Avilla 46710
Sister M. Theodora Wessell, Adm.

Strawberry Village (C)
R.R. 1, Ligonier 46767
Carole Dowden, Adm.

OHIO COUNTY

Rising Sun Nursing Home (C)
Rio Vista Ave., Rising Sun 47040
Robert Anderson, Adm.

ORANGE COUNTY

Medco Annex of French Lick (C)
R. R. 2, French Lick 47432
Jeffrey Padgett, Adm.

Medco Center of French Lick (C)
Box 350, East College, French Lick 47432
Dale C. Walters, Adm.

Paoli Nursing Home (C)
111 W. Hospital View Rd., Paoli 47454
William Howard, Adm.

OWEN COUNTY

Donna Nursing Home #2 (C)
R. R. 2, Spencer 47460
Norman S. Tirsway, Adm.

Gosport Nursing Home, Inc. (C)
South Seventh St., Gosport 47433
Leland S. Lynch, Adm.

Owen County Home (R)
R. R. 3, Spencer 47460
Ruthie Gray, Adm.

PARKE COUNTY

Castle Shannon Nursing Home (C)
R.R. 3, Box 251, Rockville 47872
Richard L. Harbison, Adm.

Parke County Nursing Home (C)
R.R. 3, Box 259, Rockville 47872
Margaret, Gerald and Dale Ball, Adms.

PERRY COUNTY

Lincoln Hills Nursing Home, Inc. (C)
19th and Pestalozzi, Tell City 47586
Patrick E. Hoesli, Adm.

PIKE COUNTY

Holiday Home (C)
Pike Ave., Petersburg 47567
Kenneth I. Dunigan, Adm.

PORTER COUNTY

Canterbury Place (C)
251 E. Drive, Valparaiso 46383
William Beilfuss, Adm.

Vale View Convalescent Center (C)
606 Wall St., Valparaiso 46383
C. Jane Graves, Adm.

Whispering Pines Home for Senior Citizens (C)
3301 N. Calumet Ave., Valparaiso 46383
Jeanette Dolk, Adm.

The Willows (C)
1000 Elizabeth, Valparaiso 46383
Nettie DuSold, Adm.

POSEY COUNTY

Allison Nursing Home Inc. (C)
Locust St., Poseyville 47633
Phyllis Duvall, Adm.

The Charles Ford Memorial Home (R)
920 S. Main St., New Harmony 47631
James J. Winterheimer, Adm.

Medco Center of Mt. Vernon, Indiana (C)
1415 Country Club Rd., Mount Vernon 47620
Lewis Brewer, Adm.

Merimac Nursing Home (C)
P. O. Box 275, Cynthiana 47612
Martha Scheller, Adm.

PULASKI COUNTY

Winamac Nursing Home (C)
515 East 13th Street, Winamac 46996
Benjamin Crandall, Adm.

PUTNAM COUNTY

Asbury Towers (R&C)
102 W. Poplar St., Greencastle 46135
Rev. Dr. Donald McMahan, Adm.

Donna Nursing Home (C)
P.O. Box 247, Cloverdale 46120
MaDonna Tirsway, Adm.

Eventide Rest Home (C)
1306 S. Bloomington St., Greencastle 46135
Ozella Stadler, Adm.

Greencastle Nursing Home (C)
815 E. Tacoma Dr., Greencastle, 46135
Harold Merrill, Adm.

Putnam County Home (R)
R. R. 5, Greencastle 46135
George H. Gentry, Adm.

Sunset Manor Nursing Home, Inc. (C)
1109 S. Indiana St., Greencastle 46135
Jack L. Cross, Adm.

RANDOLPH COUNTY

Chrystal's Country Home, Inc. (C)
Randolph St., Parker 47368
Robert E. Steele, Adm.

Parrott's Home (R)
304 W. Sherman St., Lynn 47355
Mary Maxine Parrott, Adm.

Randolph Nursing Home, Inc. (C)
701 S. Oak St., Winchester 47394
Everett Rickert, Adm.

RIPLEY COUNTY

Dreyerhaus (C)
R.R. #3, State Rd. 46, Batesville 47006
Miss Elsie Dreyer, Adm.

Health and Hospitality Center, Inc. (C)
Carr St., Milan 47031
Jon W. Kohlmeier, Adm.

Manderley Nursing Home (C)
546 Wilson St., Osgood 47037
Charles F. Negangard, Adm.

Silver Bell Nursing Home (C)
R.R. 2, Box 106, Versailles 47042
Walter Bradley, Jr., Adm.

RUSH COUNTY

Gorman's Rest Home (R)
Railroad St., Milroy 46156
Elizabeth Gorman, Adm.

Hillside Haven (C)
424 North Perkins St., Rushville 46173
Mary Todd, R.N., Adm.

Holiday House (R)
114 E. Fifth St., Rushville 46173
Inez Austerman, Adm.

Jackson Nursing Home (C)
612 E. 11th St., Rushville 46173
Marjorie Pearsey, L.P.N., Adm.

ST. JOSEPH COUNTY

Cardinal Manor (R)
118 S. William St., South Bend 46601
Delores J. Polomsky, Adm.

Cardinal Nursing Home, Inc. (C)
1121 E. LaSalle, South Bend 46601
Thomas E. Squibb, Adm.

Carlyle Nursing Home (C)
5024 N. Western Ave., South Bend 46625
Frances Gargano, Adm.

Dor-A-Lin, Inc. (C)
1024 N. Notre Dame Ave., South Bend 46617
Edward L. Finkenbinder, Adm.

Essex Nursing Home (C)
1106 South 20th St., South Bend 46615
Hugo Erickson, Adm.

Golden Age Manor (C)
811 E. 12th St., Mishawaka 46544
Rae Leonard, R.N., Adm.

Hamilton Grove (R&C)
Chicago Trail, New Carlisle 46552
Verner A. Carlson, D.D., Adm.

Healthwin Hospital (C)
20531 Darden Road, South Bend 46637
Donald Henry, Adm.

Melrose Manor (C)
601 S. Russell St., Mishawaka 46544
Richard N. Shoup, Adm.

Morningside Nursing Home (C)
18325 Bailey Ave., South Bend 46637
Sufrona Ryan, Adm.

Portage Manor (R&C)
53380 Portage Rd., South Bend 46628
Joseph W. Snyder, Adm.

Ridgedale Nursing Home (R&C)
1950 E. Ridgedale Rd., South Bend 46614
James J. Kelly, Adm.

River Park Nursing Home (C)
915 27th St., South Bend 46615
Nancy J. Jedrzejewski, Adm.

The Robert P. & Clara I. Milton Home, Inc. (R&C)
206 E. Marion St., South Bend 46601
Tessie E. Mauck, Adm.

South Bend Convalescent Center, Inc. (C)
4600 W. Washington Ave., South Bend 46619
Irene B. Gumkowski, Adm.

South Bend Nursing Home (C)
328 N. Notre Dame, South Bend 46617
Robert Cox, Adm.

Walkerton Nursing Home (C)
Walkerton Trail, Walkerton 46574
Roy J. and Ruth A. DeSimone, Adms.

SCOTT COUNTY

Roe-Seal Memorial Home (R)
Englishton Park, Lexington 47138
Janet Heilman, Adm.

Scottsburg Nursing Home (C)
1100 N. Gardner St., Scottsburg 47170
Ollie M. Blagrove, Adm.

Scott Villa Health Care Center, Inc. (C)
R.R. 6, U.S. 31 South, Scottsburg 47170
Roger A. Russell, Adm.

SHELBY COUNTY

Ace Placid Home (C)
R. R. 1, Box 350, Fairland 46126
Patsy R. Ferguson, Adm.

Conover Rest Home (C)
Box 388, Morristown 46161
Marcia Westerfield, Adm.

The Heritage House Children's Center (C)
2325 S. Miller St., Shelbyville 46176
Janet Coers, Adm.

The Heritage House Convalescent Center (C)
2309 S. Miller St., Shelbyville 46176
C. Robert Norman, Adm.

Heritage Manor, Inc. (C)
2311 S. Miller St., Shelbyville 46176
Miss Linda Kuhn, Adm.

Waldron Nursing Home (C)
Box 95, Waldron 46182
Kathleen L. and Charles D. Kuhn, Adm.

SPENCER COUNTY

Golden Circle Nursing Center (C)
Highway 68 West, Dale 47523
Donald R. Thomason, Adm.

Nursing Center of Rockport, Inc. (C)
815 Washington St., Rockport 47635
O. Jane Thomason, Adm.

Professional Care Nursing Home (C)
Dale 47523
Emma Lou Woolard, Adm.

STARKE COUNTY

The Countryside Place Health Facility (C)
300 Culver Road, Knox 46534
Al Martinez, Adm.

Little Company of Mary Health Facility, Inc. (C)
Route 421, San Pierre 46374
Thomas Kramer, Adm.

STEBEN COUNTY

Angola Nursing Home (C)
600 N. Williams St., Angola 46703
Walter D. Partin, Adm.

Carlin Park Nursing Home, Inc. (C)
P.O. Box 341, Angola 46703
Flo Shull, Adm.

SULLIVAN COUNTY

Sullivan County Lakeview Rest Home (R)
R. R. 5, Sullivan 47882
Kenneth F. and Vencil E. Engle, Adms.

Sullivan Health Care Center (C)
W. Wolfe St., Sullivan 47882
Oliver R. and Mary J. Blubaugh, Adms.

Village Nursing Home (C)
975 N. Section St., Sullivan 47882
Carla Jean McCammon, Adm.

SWITZERLAND COUNTY

Jackson's Senior Citizens Home (BHA)
501 West Pike St., Vevay 47043
Peggy Jackson, Adm.

TIPPECANOE COUNTY

Americana Nursing Center of Lafayette (C)
2201 Cason St., Lafayette 47901
William Rincker, Adm.

Comfort Retirement and Nursing Home (C)
312 N. Eighth St., Lafayette 47901
Richard E. Linson, Adm.

Hillcrest Nursing Home (C)
1123 E. South St., Lafayette 47901
Dan Wheat, Adm.

Indiana Pythian Home (R&C)
1501 South 18th Street, Lafayette 47905
Meredith E. Keeney, Adm.

Indiana Veteran's Home (BHA, R&C)
Road 43, North Lafayette 47901
Col. Stanley Arnold, Supt.

Lafayette Care, Inc. (C)
3400 Soldiers Home Rd.,
W. Lafayette 47906
Mary Robertson, Adm.

Laura M. Bowles Convalescent Home, Inc. (C)
602 Clark St., Clarks Hill 47930
Joseph Peterson, Adm.

Tippecanoe Villa (R)
5308 N. 50, W. Lafayette 47906
Charles & Dorothy Haan, Adms.

Turtle Creek Convalescent Center of Lafayette (C)
1903 Union St., Lafayette 47901
Harold Trump, Adm.

Westminster Village West Lafayette (C)
2741 N. Salisbury St., W. Lafayette 47906
J. L. Andrae, Adm.

TIPTON COUNTY

The Higgins Home, Inc. (C)
R.R. 1, St. Rd. 19, Box 303,
Tipton 46072
Robert D. Higgins, Jr., Adm.

Holtsclaw Nursing Home (C)
119 W. Washington St., Tipton 46072
Margaret Holtsclaw, Adm.

Tipton Nursing Home (C)
701 E. Jefferson St., Tipton 46072
Marcia Ellen DeWitt, R.N., B.S., Adm.

UNION COUNTY

Park Manor Nursing Home, Inc. (C)
409 E. Union St. Liberty 47353
Elaine Stubbs, R.N., Adm.

VANDERBURGH COUNTY

Bethel Sanitarium, Inc. (R&C)
6015 Kratzville Rd., Evansville 47710
Louise Kuiken, R.N., Adm.

Braun's Nursing Home, Inc. (C)
909 First Ave., Evansville 47710
Ruth H. Braun, L.P.N., Adm.

Christian Manor (C)
923 S. Elliott St., Evansville 47710
James Camp, Adm.

Dellaren Nursing Care Center (C)
816 North First Ave., Evansville 47710
Dorothy A. Arendell, Adm.

Evansville Protestant Home Inc. (R&C)
3701 Washington Ave., Evansville 47715
Helen E. Kinkle, Adm.

Gertha's Nursing Home, Inc. (C)
605 Oakley St., Evansville 47710
Richard Gossman, Sr., Adm.

Good Samaritan Home, Inc. (C)
601 N. Boeke, Evansville 47711
N. R. Allsmiller, Adm.

Holiday Home (C)
1201 W. Buena Vista Rd., Evansville 47710
Larry E. Dunigan, Adm.

M & R Nursing Home (C)
1100 N. Read St., Evansville 47710
Mike Cox, L.P.N., Adm.

McCurdy Residential Center (R)
101 S.E. First St., Evansville 47713
Ronald E. Deckard, Adm.

Medco Center of Evansville-North, Inc. (C)
650 Fairway Dr., Evansville 47710
Charles Rustem, Adm.

Parkview Convalescent Center, Inc.
2819 N. St. Joseph Ave., Evansville 47712
Charles J. Lucwyck, Adm.

Pine Haven Nursing Home (C)
3401 Stocker Dr., Evansville 47712
James F. Stocker, R.N., Adm.

Pleasantview Rest Home (R&C)
700 Senate Ave., Evansville 47711
Jack Harness, Adm.

Quality Care Home (C)
807 S.E. Third St., Evansville 47713
Dorothy Wolf, Adm.

Rathbone Memorial Home (R)
1320 S. E. Second St., Evansville 47713
Peter Mulvey, Adm.

Regina Pacis Home (R&C)
3900 Washington Ave., Evansville 47715
Raymond Heinen, Adm.

St. John's Home for the Aged (R&C)
1236 Lincoln Ave., Evansville 47714
Sr. Genevive Lanahan, Adm.

Turtle Creek Convalescent Center of Evansville (C)
4301 Washington Ave., Evansville 47715
Evelyn Hendrix, Adm.

VERMILLION COUNTY

Clinton Nursing Home (C)
700 S. Main St., Clinton 47842
Betty June Payton, L.P.N., Adm.

Holiday Home (C)
Outer S. Main St., Clinton 47842
R. C. Bunnell, Adm.

VIGO COUNTY

Canterbury Convalescent Centre (C)
500 Maple Ave., Terre Haute 47804
Marilyn A. Williams, Adm.

Clara Fairbanks and Chauncey Rose Home, Inc. (R&C)
721 Eighth Ave., Terre Haute, 47804
Helen Cottrell, R.N., Adm.

Ewing Nursing Home (C)
504 S. 15th St., Terre Haute 47807
Mary Cox Ewing, R.N., Adm.

Meadows Manor (C)
3300 Poplar St., Terre Haute 47803
Wilma P. Hall, Adm.

Meadows Manor North, Inc. (C)
3150 N. 7th St., Terre Haute 47804
Marjorie Loving, R.N., Adm.

Terre Haute Nursing Home (C)
830 S. 6th St., Terre Haute 47808
Charles C. Moyer, Adm.

Vigo County Home (C)
3500 Maple Ave., Terre Haute 47804
Margaret Koile, Adm.

Wallace Nursing Center, Inc. (C)
120 W. Margaret Ave., Terre Haute 47802

Richard D. Wallace, Adm.

Webster's Rest Home (C)
513-15 North 14th St., Terre Haute 47807
Rachel Webster, Adm.

WABASH COUNTY

Americana Healthcare Center of Wabash (C)
654 Washington St., Wabash 46992
N. Maxine McIlwain, Adm.

The Estelle Peabody Memorial Home of the United Presbyterian Church, U.S.A., Indiana Synod (R&C)
Seventh and Buffalo,
North Manchester 46962
William Visser, Adm.

Merriweather Convalescent Home (C)
1720 Alber St., Wabash 46992
Miss Kathryn Duffey, R.N., Adm.

Miller's Merry Manor, Inc. (C)
1035 Manchester Ave., Wabash 46992
Jack Hobbs, Adm.

Pleasant View Nursing Home (C)
R. R. 2, Wabash 46992
Daniel H. Miller, R.N., Adm.

The Shangri-La (C)
604 Rennaker St., La Fontaine 46940
Larrie L. Falder, Adm.

Timbercrest-Church of the Brethren Home (R&C)
East St., North Manchester 46962
Orville Sherman, Adm.

Vernon Manor for Children Home (C)
P.O. Box 258, Wabash 46992
John W. Bishop, Adm.

WARREN COUNTY

Davis Boarding Home (BHA)
R. R. #2, Covington 47932
John W. Davis, Adm.

Meadows Heights Nursing Center (C)
200 Short St., Williamsport 47993
Archer A. Cogil, Adm.

WARRICK COUNTY

Baker's Rest Haven, Inc. (C)
305 E. North St., Boonville 47601
Viola Vance, R.N., Adm.

Medco Center of Chandler (C)
R. R. 2, Chandler 47610
Stan Copeland, Adm.

Monticello Manor (C)
S.E. Second St., Boonville 47601
Melvin H. White, Adm.

WASHINGTON COUNTY

Williams Convalescent Center, Inc. (C)
Homer and Anson Sts., Salem 47167
Wayne H. Williams, and Kathleen Williams, L.P.N., Adms.

WAYNE COUNTY

Colonial Crest Convalescent Center Richmond (C)
1042 Oak Dr., Richmond 47374
Dennis Ryan, Adm.

Friends Fellowship Community, Inc. (R&C)
2030 Chester Blvd., Richmond 47374
Merrill W. Baxter, Adm.

Golden Rule Nursing Center, Inc. (C)
2001 U.S. 27 South, Richmond 47374
Al Knobler, Adm.

Heritage House of Richmond, Inc. (C)
2070 Chester Blvd., Richmond 47374
Sam M. Simmons, Adm.

Jenkins Hall (R&C)
N. 10th St., Richmond 47374
Kenneth R. Spoon, Adm.

Owens Convalescent Home Inc. (C)
1811 S. Ninth St., Richmond 47374
Bonnie Owens, Adm.

Pinehurst Nursing Home (C)
Box 145, Centerville 47330
Mary McClure, R.N., Adm.

Richmond Nursing Home (C)
2302 N. Chester Blvd., Richmond 47374
Robert Addington, Adm.

WELLS COUNTY

Cooper Rest Homes, Inc. (C)
1509 Fort Wayne Rd., Bluffton 46714
Daniel J. Cooper, Adm.

Davis Bluffton Nursing Home (C)
1001 S. Clark Ave., Bluffton 46714
I. Helen Jackson, Adm.

Meadowvale Skilled Care Center (C)
1529 W. Lancaster St., Bluffton 46714
Donald Cheesman, and Alva Cheesman,
Adms.

WHITE COUNTY

**Archibald Memorial Home for Aged
Deaf (R)**
R. R. 2, Brookston 47923
Laura L. Peterson, Adm.

Lake View Home (R)
R. R. 6, Monticello 47960
Ora Rumble, Adm.

**Turtle Creek Convalescent Centre of
Monticello (C)**
R. R. 6, Monticello 47960
Mr. Kristen W. Baldock, Adm.

WHITLEY COUNTY

Alfran Nursing Home, Inc. (C)
R. R. 9, Columbia City 46725
Elson Wilson, L.P.N., Adm.

Columbia City Nursing Home (C)
522 N. Line St., Columbia City 46725
Vera Stauffer, Adm.

Mary Farris Nursing Home (C)
215 E. VanBuren, Columbia City 46725
Mary Farris, Adm.

Miller's Merry Manor, Inc. (R&C)
710 W. Ellsworth St., Columbia City
46725
Grace M. Karst, R.N., Adm.

Indiana University School of Medicine

1100 W. Michigan Street, Indianapolis 46202
Steven C. Beering, M.D., Indianapolis, Dean

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List of Indiana Accredited Programs In Nursing Preparing for Licensure As Registered Nurses

INDIANA STATE BOARD OF NURSES' REGISTRATION AND NURSING EDUCATION

700 High School Road, Indianapolis 46224

April 1977

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Name of School of Nursing	Location	Director	Zip Code
Deaconess Hospital	Evansville	Miss Ellen Lynch, R.N.	47747
Lutheran Hospital	Fort Wayne	Miss Virginia Williamson, R.N.	46807
Parkview-Methodist	Fort Wayne	Miss Dorothy Craig, R.N.	46805
St. Joseph Hospital	Fort Wayne	Miss Josephine Schweier, R.N.	46804
Wishard Memorial Hospital	Indianapolis	Ms. Shirley Ross, R.N., Acting	46202
St. Elizabeth Hospital	Lafayette	Sister M. Florianne, R.N.	47904
Memorial Hospital	South Bend	Miss Irene M. Kardasen, R.N.	46601

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Name of School of Nursing	Location	Director, Dean or Head of Department	Zip Code
Univ. of Evansville	Evansville	Mrs. Helen C. Smith, R.N., Dean	47702
Goshen College Div. of Nursing	Goshen	Mrs. Marilyn Leichty, R.N., Interim Director	46526
DePauw University 1812 N. Capitol	Indianapolis	Ms. Doris Froebe, R.N., Director	46202
Indiana University (IUPUI) 1100 W. Michigan St.	Indianapolis	Mrs. Elizabeth Grossman, R.N., Dean	46202
Marion College Dept. of Nursing	Marion	Miss Wilma Jean Jackson, R.N.	46952
Ball State University Dept. of Nursing	Muncie	Miss Helen J. Berry, R.N., Head	47306
Saint Mary's College Dept. of Nursing	Notre Dame	Mary Elizabeth Martucci, R.N., Chairman	46556
Indiana State University	Terre Haute	Mrs. Mary Anne E. Roehm, R.N., Interim Dean	47809
Valparaiso University College of Nursing	Valparaiso	Mrs. Dorothy Paulsen Smith, R.N., Dean	46383

ASSOCIATE DEGREE PROGRAMS

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Anderson College Dept. of Nursing	Anderson	Richard O. Hakes, R.N.	46011
University of Evansville ADN Program	Evansville	Mrs. Nadine Coudret, R.N.	47702
Indiana University ADN Programs: I.U. Northwest, 3400 Broadway	Gary	Mrs. Doris R. Blaney, R.N.	46408
I.U.P.U.I., 1100 W. Michigan St.	Indianapolis	Miss Margaret Applegate, R.N.	46202
I.U. Southeast, Div. of Nursing 4201 Grant Line Road P.O. Box 679	New Albany	Ms. Louise F. Suleiman, R.N.	47150
I.U. Kokomo, 2300 S. Washington	Kokomo	Mrs. Florence Gardner, R.N.	46901
Indiana Central College Dept. of N.	Indianapolis	Mrs. LeAlice Briggs, R.N.	46227
Marian College	Indianapolis	Miss Mary Ann Lewis, R.N.	46222
Purdue University Nursing Sections: Ft. Wayne Campus, 2101 Coliseum Blvd.	Ft. Wayne	Mrs. Elaine Cowen, R.N., Chairman	46805
Calumet Campus, 2233-171st Street	Hammond	Mrs. Joyce A. Ellis, R.N., Chairman	46323
Lafayette Campus, S. Campus Courts	West Lafayette	Miss Helen Zink, R.N., Chairman	47907
North Central Campus	Westville	Miss Bernice Schaapveld, R.N., Chairman	46391
Vincennes University	Vincennes	Miss Stella Risch, R.N., Chairperson	47591

Indiana Accredited Programs in Practical Nursing

April 1977

School or Program		Director, School or Program
Anderson School of Practical Nursing Anderson Community Schools 325 W. 38th St., Anderson	46014	Mrs. Virginia Blakeley, R.N., Director
Indiana Vocational Technical College Schools of Practical Nursing Region 10, 725 W. 2nd St., Bloomington	47401	Mrs. Lois Ahlhauser, R.N.
Region 10, 2518 E. 17th St., Columbus	47201	Mrs. Margaret Watson, R.N.
Region 4, 2316 South St., Lafayette	47904	Ms. Sharon Bingaman, R.N.
Region 1, 1511 Wabash St., Mich. City	46360	Miss Virginia Melevage, R.N.
Region 9, Reid Memorial Hosp. 1401 Chester Blvd., Richmond	47374	Mrs. Joan Esarey, R.N.
Region 2, 1534 W. Sample St., S. Bend	46619	Miss Dorothy Bupp, R.N., Dept. Chairman
Region 7, R. R. #22, Box 450, T. Haute	47802	Mrs. Betty Fowler, R.N., Chairman Life Sciences
Evansville School of Practical Nursing Evansville-Vanderburgh School Corp., 1900 Stringtown Road, Evansville	47711	Miss Joyce Stevens, R.N., Coordinator
School of Practical Nursing Fort Wayne Community Schools, 1200 South Barr, Fort Wayne	46802	George F. Walls, R.N., Coordinator Health Occupations
School of Practical Nursing Indianapolis Public Schools 26 N. Arsenal Ave., Indianapolis	46201	Mrs. Marguerite F. Clark, R.N., Director
Metropolitan School District of Washington Twp. J. Everett Light Career Center 1901 E. 86th St., Indianapolis	46240	Mrs. Madlon Drayer, R.N., Director
Kokomo School of Practical Nursing Kokomo-Center Twp. Cons. Sch. Corp., 1104 N. Bell, Kokomo	46901	Mrs. Geraldine Huber, R.N., Director-Coordinator
Marion Community School of Practical Nursing Tucker Area Career Center 750 W. 26th St., Marion	46952	Mrs. Esther Fritts, R.N., Instructor-Supervisor
Muncie School of Practical Nursing Ball Memorial Hospital 2300 West Gilbert Street, Muncie	47303	Mrs. Norma Lewis, R.N., Director
New Albany School of Practical Nursing New Albany-Floyd Co. Cons. Sch. Corp. 4202 Charlestown Rd., New Albany	47150	Mrs. Phyllis Thacker, R.N., Director-Instructor
Vincennes University Practical Nurse Program, Vincennes	47591	Ms. Karen Gines, R.N., Director

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5221 Ivy Tech Drive, Indianapolis 46206, tele-
phone 317-297-3210, offers the following health
occupation courses at the locations listed:

GARY

1440 East 35th Ave.

Gary 46409

Offers courses to prepare:
Emergency Care Technician
Medical Assistant
Operating Room Technician
Practical Nursing
Respiratory Therapy Technician
Dietetic Assistant
Emergency Medical Technician—
Ambulance

SOUTH BEND

1534 West Sample St.

South Bend 46619

Offers courses to prepare
Medical Assistant
Operating Room Technician
Practical Nursing
Laboratory Assistant
Dietetic Assistant
Emergency Medical Technician—
Ambulance

LAFAYETTE

616 Wabash Ave.,

Lafayette 47905

Offers courses to prepare:
Laboratory Assistant
Dental Assistant
Emergency Care Technician
Medical Assistant
Operating Room Technician
Practical Nursing
Respiratory Therapy Technician
Emergency Medical Technician—
Ambulance

KOKOMO

3717 South Reed Rd.,

Kokomo 46901

Offers courses to prepare:
Medical Assistant

MUNCIE

1300 South Liberty St.,

Muncie 47302

Offers courses to prepare:
Medical Assistant
Emergency Medical Technician—
Ambulance

TERRE HAUTE

R. R. 22, Box 450

Terre Haute 47802

Offers courses to prepare:
Medical Assistant
Practical Nursing
Laboratory Assistant

INDIANAPOLIS

1315 East Washington St.

Indianapolis 46202

Offers courses to prepare:
Medical Laboratory Technician
Emergency Care Technician
Medical Assistant
Operating Room Technician
Radiologic Technology
Respiratory Therapy Technician
Emergency Medical Technician—
Ambulance

RICHMOND

710 Northwest 5th St.

Richmond 47374

Offers courses to prepare:
Laboratory Assistant
Practical Nursing

COLUMBUS

646 Franklin St.

Columbus 47201

Offers courses to prepare:
Practical Nursing

BLOOMINGTON

619 West First St.

Bloomington 47401

Offers courses to prepare:
Practical Nursing

JEFFERSONVILLE

610 Spring Street

Jeffersonville 47130

Offers courses to prepare:
Medical Assistant
Operating Room Technician (Accreditation Pending)
Emergency Medical Technician—
Ambulance

MADISON

1st and Broadway

Madison 47250

Medical Assistant

* DISEASE PREVENTION by Immunization and Chemoprophylaxis

Disease	Agent Used	Recommended For	Method of Administration			Type of Immunity	Duration of Protection	Booster Injection
Cholera	Cholera Vaccine	Travelers vaccinated in the United States require only one dose of cholera vaccine (dose number one in table at right) and should receive the second dose only if they will be traveling or working in areas where cholera is epidemic or endemic and sanitation is less than adequate.	Dose Number	Under 5	Age (years) 5-10 Over 10	Active	6 months	Should be given every six months as long as likelihood of exposure exists. Same volume as dose number two of primary series.
			1	0.1 ml	0.3 ml			
			2	0.3 ml	0.5 ml 1.0 ml			
Diphtheria	Diphtheria Antitoxin	All early cases	Intravenous preferred. Warning: Test for sensitivity to horse serum. Dosage dependent on degree of toxicity rather than age and weight. 20,000 units to 120,000 units.			Passive	Short	Additional antitoxin given dependent upon illness and toxicity.
Diphtheria	Diphtheria toxoid (alum precipitated or aluminum phosphate adsorbed, for adult use, 2 lf of antigen).	Children and adults. Use only when there are definite contraindications to other components of combined antigen (DPT or Td).	Two intramuscular injections of 0.5 cc. each, four to six weeks apart and third dose one year later.			Active	Indefinite	0.5 cc. every 10 years.
Diphtheria	Diphtheria-Pertussis-Tetanus alum precipitated or aluminum hydroxide (or aluminum phosphate) adsorbed diphtheria and tetanus toxoids; containing 12 protective antigenic units of vaccine per 1.5 cc. (DPT)	Children two months through six years.	Three intramuscular injections of 0.5 cc each, one month apart followed by reinforcing dose one year after third dose. Series should begin at 6 weeks to 3 months of age.			Active	Indefinite	D-P-T booster of 0.5 cc. at 3-6 years. (Preferably at time of school entrance—kindergarten or elementary school.)
Diphtheria	Tetanus and Diphtheria Toxoids, adult type (Td-containing 2 lf of diphtheria toxoid).	Children and adults (Diphtheria-Pertussis-Tetanus combination is preferred for children under 6 years of age, except when pertussis component contraindicated.)	Primary immunization: (1) First dose of 0.5 cc. IM or subcu (2) Second dose of 0.5 cc. IM or subcu 4-6 weeks later. (3) Reinforcing dose one year after (2)			Active	Indefinite	Diphtheria Tetanus (Td) booster every 10 years.
Hepatitis, Infectious (Type A)	Immune Serum Globulin (Gamma Globulin)	All exposed in household, institution, etc.	Dosage: 0.01 cc. per pound of body weight. Given intramuscularly.			Passive	Brief	Repeat each exposure

Influenza	Polyvalent Vaccine (Subject to annual changes in recommendations late summer or fall)	Persons with chronic debilitating disease of heart and lungs and those with chronic metabolic disorders, especially diabetes mellitus. Consider for all older age persons, especially those with incipient or potentially chronic heart or lung disease.	One dose subcutaneously	Active	60-90% effective, at least ne year.	One dose annually
Measles	Live, "Further Attenuated" Vaccine	15 months and older	Single dose subcutaneously	Active	At least 15 years. May be lifelong	Reimmunize children previously immunized at less than 12 months of age; also, those who received only inactivated vaccine or a combined series of inactivated and live vaccines.
Mumps	Mumps Virus Vaccine, Live, Attenuated	Children 12 months or older Adults who have not had mumps	One dose subcutaneously	Active	Eight years known—probably much longer	Not known at present
Meningococcal Meningitis	Rifampin	Intimate contacts of a case	Adults: 600 mg. orally twice daily for two days. Children: 10 mg/kg twice a day for two days for children age 1 to 12 years; 5 mg/kg twice daily for two days for infants age 3 month to 1 year.	None Chemical prophylaxis only	Very brief—for one exposure only.	Repeat following each exposure.
	Minocycline	Same	Adults: 100-200 mg. orally every 12 hours for five days (caution: vestibular reactions reported)			
	Sulfadiazine	Same: use only for proven sulfa-sensitive meningococcus	Twelve years of age or older: 1.0 gm twice daily for 2 days. Under 12 years of age: 0.5 gm twice daily for 2 days.			
	Meningococcal polysaccharide vaccines, monovalent group C, and bivalent A-C.	Routine use not recommended. Selective use for: control of outbreaks due to <i>N. meningitidis</i> serogroups A or C; some travelers to countries having epidemic meningococcal disease; adjunct to chemoprophylaxis for household contact of meningococcal disease cases.	One dose parenterally, volume specified by manufacturer.	Active. Children less than two years old respond less well to the Group A antigen than do older persons; the Group C antigen is not effective in children less than two years of age.	Unknown	Insufficient data.

Disease	Agent Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection																		
Pertussis	Pertussis Vaccine saline suspended (See Double and Triple antigens under "Diphtheria")	Children during epidemic	A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units (0.5 cc.) given subcutaneously at intervals of one week.	Active	Indefinite	1 year after primary series, 2 years after primary series and then every three years to 6 or 7 years of age.																		
	Pertussis Vaccine alum precipitated or aluminum hydroxide adsorbed (See Double and Triple antigens under "Diphtheria")	Routine immunization of infants when DPT is contraindicated	A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units each (0.5 cc.) injected intramuscularly at intervals of 4 to 6 weeks.	Active	Indefinite	18 months—3-4 years. 6-7 years usually given as DPT.																		
Plague	Plague Vaccine—a suspension of 2000 million killed Pasteurella per milliliter	Exposure Recall		Active	Indefinite	4 NIH units (0.5 cc.) saline suspension subcutaneously if child has not had immunization past 2 years.																		
		Epidemics and areas with high endemic rate.	<table><tr><th>Dose No.</th><th>Under 1 year</th><th>1-4</th><th>5-10</th><th>Over 10</th></tr><tr><td>1</td><td>0.1 ml</td><td>0.2 ml</td><td>0.3 ml</td><td>0.5 ml</td></tr><tr><td>2</td><td>0.1 ml</td><td>0.2 ml</td><td>0.3 ml</td><td>0.5 ml</td></tr><tr><td>3</td><td>0.04 ml</td><td>0.08 ml</td><td>0.12 ml</td><td>0.2 ml</td></tr></table>	Dose No.	Under 1 year	1-4	5-10	Over 10	1	0.1 ml	0.2 ml	0.3 ml	0.5 ml	2	0.1 ml	0.2 ml	0.3 ml	0.5 ml	3	0.04 ml	0.08 ml	0.12 ml	0.2 ml	Active
Dose No.	Under 1 year	1-4	5-10	Over 10																				
1	0.1 ml	0.2 ml	0.3 ml	0.5 ml																				
2	0.1 ml	0.2 ml	0.3 ml	0.5 ml																				
3	0.04 ml	0.08 ml	0.12 ml	0.2 ml																				
Poliomyelitis*	Poliomyelitis trivalent oral (Sabin)	Infants Children Adults	First dose 6-12 weeks, 2nd dose 8 weeks later 3rd dose 8-12 months after 2nd. Children, two doses 6-8 weeks apart; third dose 8-12 months after second. Not necessary in U.S. but if at risk may be immunized as are children.	Active	Thought to be permanent	1 dose trivalent on entering school.																		
	Poliomyelitis (Salk) Vaccine	All Ages	Four parenteral doses; three at 1 month intervals; fourth 6-12 mo. after #3	Active	Not known (Salk has demonstrated adequate antibodies present after 8 years)	1 cc every 2-3 years Need for boosters obviated by full course of Oral Polio Vaccine																		
Rabies (post exposure prophylaxis)	Rabies hyper-immune serum: a) Rabies immune globulin (human) b) Antirabies serum (equine) Rabies vaccine-duck embryo (DEV).	Bites by animals with known or suspected rabies; also, non bite exposures involving contamination of scratches, abrasions, open wounds or mucous membranes with saliva from such animals.	Hyperimmune serum, one dose as soon as possible after exposure. Begin 21-dose rabies vaccine series simultaneously; this may be given as 21 daily doses or two doses daily for seven days followed by one dose daily for seven days.	Passive immunity from hyperimmune serum. Active immunity from DEV.	Serum—few weeks. Vaccine—indefinite.	Vaccine booster tenth and twentieth day after last dose of DEV series. Collect serum for rabies antibody testing at time of second booster.																		

Rabies (pre-exposure prophylaxis)	Rabies vaccine—duck embryo (DEV).	High-risk groups, e.g., veterinarians, animal handlers, certain laboratory workers, spelunkers, etc.	Two doses DEV one month apart followed by third dose in six-seven months (80%-90% response); or, three doses DEV at weekly intervals and fourth dose three months later (80% response).	Active. Test serum for rabies antibodies three-four weeks after last dose; if negative, give booster doses until response indicated.	Two years.	Routine: vaccine booster every two years. Exposure by rabid animal: Five daily doses of DEV followed by booster dose 20 days after fifth dose.
Rubella	Live virus vaccine	All children ages 1-12 yrs.	1 dose subcutaneously	Active	At least 5 yrs—Long term protection likely	Not known at present
Rocky Mountain Spotted Fever	Rocky Mountain Spotted Fever Vaccine	Not routinely recommended since advent of specific antibiotic therapy. May be used in areas of high incidence among persons of high risk.	Adults: 3 injections each 1.0 cc. subcutaneously or intramuscularly at intervals of one week. Children—under 10 years three injections each 0.5 cc. subcutaneously or intramuscularly at intervals of one week.	Active	One year	1.0 cc. booster (annually under conditions of continued high risk of exposure.
Smallpox	Smallpox Vaccine (Vaccinia virus)	Travelers to and from countries where smallpox is still endemic or to countries requiring vaccination for entry.	Multiple pressure, jet injection, or other techniques shown to be equally effective in assuring takes.	Active	3-10 years	Foreign travel — every 3 years.
Tetanus	Tetanus Immune Globulin (Human) (TIG)	Unimmunized persons, especially those with crushing injuries, burns, or penetrating wounds; also, for persons seen more than 24 hours after tetanus-prone injury who have had no tetanus toxoid for many years.	Adults: 250 units IM for wounds of average severity, up to 500 units for very severe wounds; children: 4 units per kilogram body weight.	Passive	21 days	Must repeat with each injury. Immunization with tetanus toxoid obviates need for further TIG.
	Tetanus Antitoxin Use only if Tetanus Immune Globulin (Human) is unavailable.	All cases of puncture wounds and animal bites when person has not been immunized for more than 5 years since last booster.	Caution: Skin test first for serum sensitivity. Intramuscular injection of 3000-10,000 units anti-toxin.	Passive	10 days	Repeat with each injury. Because of hazard to horse serum active immunization with toxoid preferred.
	Tetanus Toxoid, depot (alum precipitated or adsorbed) (See Double and Triple antigens under "Diphtheria")	Hypersensitivity to other components of DTP and Td.	Two doses, each 0.5 cc. given intramuscularly, not less than four weeks apart followed by a reinforcing injection 8-12 months later.	Active	Extremely long lasting	Every 10 years

Disease	Vaccine Used	Recommended For	Method of Administration	Type of Immunity	Duration of Protection	Booster Injection
Typhoid fever	Typhoid Vaccine	Exposure to a carrier in a household; outbreaks of typhoid fever in a community; travel to areas where typhoid fever is endemic.	Adults and children over 10 years old: 0.5 ml subcutaneously on two occasions, separated by 4 or more weeks. Children less than 10 years old: 0.25 ml subcutaneously on two occasions, separated by 4 or more weeks. If more rapid immunization is required, 3 doses of the same volume listed above may be given at weekly intervals but this schedule may be less effective.	Active	Indefinite—at least 3 yrs.	Every one to three years under conditions of continued or repeated exposure. Adults and children over 10 years old: 0.5 ml subcutaneously or 0.1 ml intradermally. Children 6 mo. to 10 yrs: 0.25 ml subcutaneously or 0.1 ml intradermally
Typhus Fever	Typhus Fever Vaccine	Not required for travelers to any part of the world. Suggested for persons living or working in close contact with certain indigenous populations in remote areas of South America, Africa and Asia.	Adults Two doses, each 0.5 cc. at intervals of 4 or more weeks given subcutaneously. Allergy to egg or chicken protein only contraindication. Children under 10 years; one half of adult dose.	Active	Relative 6-12 months	Every 6-12 months as long as opportunity for exposure exists. Same dose as in initial series.
Yellow Fever	Yellow Fever Vaccine ³ (Obtainable only at U. S. P. H. S. Hospital or Yellow Fever Immunization Depots. See footnote where obtainable in Indiana.)	All persons traveling in or through or living in endemic areas. Should receive vaccine 10 days before arrival in area.	One dose 0.5 cc. of a 1:10 dilution of concentrated vaccine, freshly prepared. Given subcutaneously. Should not be given to person ill with virus disease.	Active	10 years	Every 10 years repeat immunization.

* While many contraindications are listed for various biologicals, it should be recognized that in the interest of brevity it was impossible to give all details. In case of doubt consult standard reference for detailed description of biological in question and/or pharmaceutical company's circular accompanying original package of biological.

All of the biologicals listed may be obtained through normal supply channels with the exception of YELLOW FEVER VACCINE. Because of hazards if yellow fever vaccine is improperly handled, it can only be obtained from U.S.P.H.S. depots. In Indiana these depots are: (See next page.)

Interruption Of Recommended Pediatric Immunization Schedule

Interruption of the recommended schedule, with a delay between doses, does not interfere with the final immunity achieved; nor does it necessitate starting the series over again, regardless of the length of time elapsed.

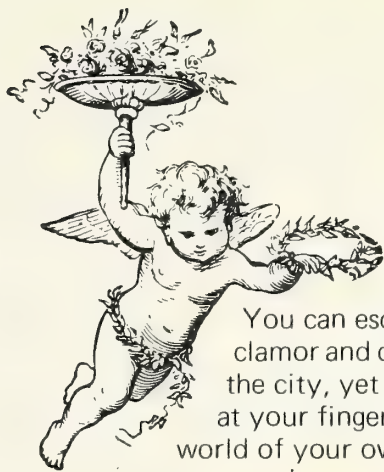
U.S.P.H.S. Depots in Indiana

LOCATION	CENTER	CLINIC HOURS (Subject to Change)	FEE
INDIANA			
Crown Point	Lake County Health Dept. Lake County Government Center 2293 North Main St. 46307 219,663-0760 or 738-2020	Wed., 8:30-12	Yes
Elkhart	County Health Unit 315 South Second St. 46514 219,294-1688 Ext. 261	First and third Wed., 10-11 a.m.	Yes
Evansville	Evansville-Vanderburgh County Health Dept. Civic Center Complex Room 129, Administration Bldg. 7th and Main Sts. 47708 812,426-5685	By appointment Mon., 2:30 p.m.	Yes
Fort Wayne	Fort Wayne-Allen County Board of Public Health Fifth Floor City-County Bldg. 46802 219,423-7504	Wed., 9-10 a.m.	Yes
Gary	City Health Dept. 1145 W. 5th 46402 219,944-6766	By appointment	Yes
Indianapolis	Indiana University 1100 West Michigan St. 46202 317,264-8123	Fri., 9:30 a.m.	Yes

Physicians having patients requiring yellow fever immunization should advise person to call or write the above, as inoculations are given by appointment only on one day a week. There is a fee to cover vaccine and administration.
(Revised)

Communicable Disease Control Division
Indiana State Board of Health
April 1977

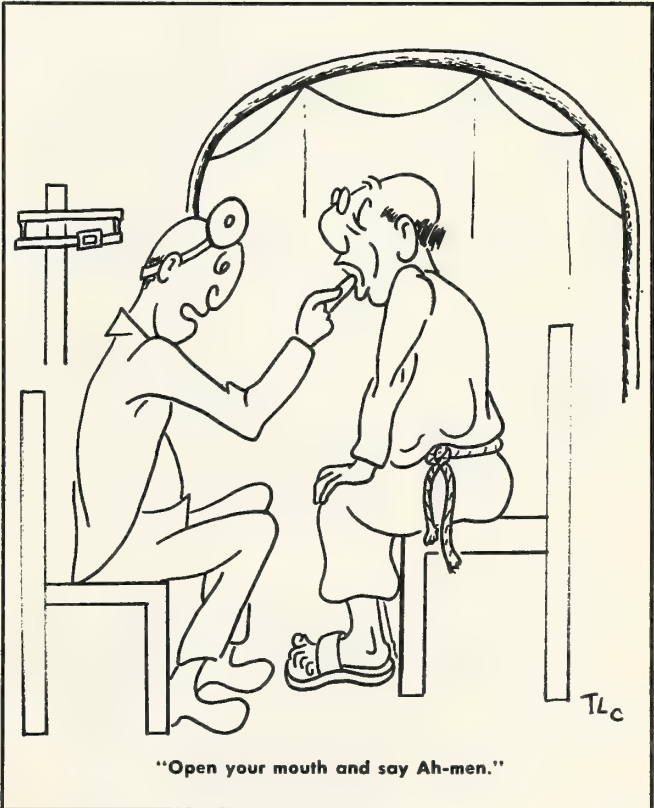
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Poison Control Centers in Indiana

and Adjacent States

***ATTENTION: Physicians, Hospitals and Poison Control Centers.

Since July 1, 1965, Wishard Memorial Hospital, Indianapolis, has been the principal INFORMATION CENTER for the state of Indiana, replacing that service provided by the Indiana

State Board of Health. If you need help in determining the toxic ingredients in a "trade name product" or have a problem involving treatment of a poisoning case, please call WISHARD MEMORIAL (Marion County General) HOSPITAL, INDIANAPOLIS — 639-6671.

City	Name and Address	Telephone	Director
Anderson	St. John's Memorial Hospital 2015 Jackson Street	649-2511 Ext. 251	Thomas Schrader, Pharm.
Angola	Cameron Memorial Hospital, Inc. 416 E. Maumee	665-2141	Marie Hosack, R.N.
Bedford	Dunn Memorial Hospital 1616 23rd Street	275-3331	Richard T. Simmons, R. Ph.
East Chicago	St. Catherine Hospital 4321 Fir Street	392-7203	Stanley Zallen, M.D.
Elkhart	Elkhart General Hospital 600 East Boulevard	294-2621	C. Richard Yoder, M.D.
Evansville	Protestant Deaconess Hospital 600 Mary Street	426-3405	Robert Arendell, M.D.
Evansville	St. Mary's Hospital, Inc. 3700 Washington Avenue	477-6261 Ext. 491	A. S. Ritz, M.D.
Evansville	Welborn Memorial Baptist Hospital, Inc. 412 S. E. Sixth Street	426-8336	Richard Emig, R. Ph.
Fort Wayne	Parkview Memorial Hospital 2200 Randalia Drive	484-6636	William O. Wissman, Pharm.
Fort Wayne	St. Joseph Hospital 730 West Berry Street	423-2614	Robert Voorhees, M.D.
Frankfort	Clinton County Hospital 1300 S. Jackson Street	654-4451 Ext. 22	Fred W. Flora, M.D.
Gary	Methodist Hospital of Gary, Inc. 1600 West 6th Avenue	886-4710	Darline Lee, R.N.
Goshen	Goshen General Hospital 200 High Park Avenue	533-2141 (Emergency Room)	Craddock Duren, M.D.
Hammond	St. Margaret Hospital 25 Douglas Street	932-2300 Ext. 700	Herbert I. Arbeiter, M.D.
Indianapolis	Wishard Memorial Hospital 1001 West 10th Street	639-6671	Carolyn Cunningham, M.D.
Indianapolis	Methodist Hospital of Indiana, Inc. 1604 North Capitol Ave.	924-8355	Maxine Bush, R.N.

POISON CONTROL CENTERS

Continued

City	Name and Address	Telephone	Director
Indianapolis	St. Francis Hospital Center 1600 Albany Street Beech Grove	783-8261	J. R. Coughenoor, M.D.
Kokomo	Howard Community Hospital 3500 S. Lafountain St.	453-8444	Mary Scheetz, R.N.
Lafayette	St. Elizabeth Hospital 1501 Hartford Street	742-0221 Ext. 421 or 428	Howard Gish, M.D.
LaGrange	LaGrange County Hospital R.R. #1	463-2144 Ext. 34	Sharon Honaker, R.N.
Lebanon	Witham Memorial Hospital 1124 N. Lebanon Street	482-2700 Ext. 44	Thomas Dillon, D.O.
Madison	The King's Daughters' Hospital 112 Presbyterian Ave.	265-5211	Mrs. Ester Stiles, R.N.
Marion	Marion General Hospital Wabash and Euclid Avenue	662-4694	L. D. Wojcik, M.D.
Mishawaka	St. Joseph Hospital 215 West 4th Street	259-2431 Ext. 233	
Muncie	Ball Memorial Hospital 2401 University Avenue	747-3241	Joyce Hartley, R.N.
Portland	Jay County Memorial Hospital 505 West Arch Street	726-7131 Ext. 159	R. K. Riesz, M.D.
Richmond	Reid Memorial Hospital 1401 Chester Blvd.	962-4545	Mrs. Jewell Spears, R.N.
Shelbyville	William S. Major Hospital 150 W. Washington Street	392-3793	Carolyn Rosenfeld, R.N.
South Bend	Memorial Hospital of South Bend Poison Control Center 615 North Michigan Street	284-7458	Z. Myers, M.D.
South Bend	St. Joseph Hospital 811 East Madison Street	233-0040	B. Vagner, M.D.
Terre Haute	Union Hospital, Inc. 1606 N. Seventh Street	232-0361 Ext. 397	Darrell Propst, R. Ph.

ADJACENT STATES

City	Name and Address	Telephone	City	Name and Address	Telephone
Illinois					
Chicago	Poison Control Center Presbyterian—St. Luke's Hospital 1753 W. Congress Pkwy.	942-5969	St. Louis	Poison Control Center St. Louis Children's Hospital 500 S. Kingshighway	367-6880
Kentucky					
Louisville	Poison Control Center Department of Pediatrics 226 E. Chestnut St.	582-1831			
Missouri					
St. Louis	Poison Control Center Cardinal Glennon Memorial Hospital for Children 1465 S. Grand Ave.	865-4446	Cincinnati	*Poison Control Center Cincinnati General Hospital	872-5111
			Columbus	Poison Control Center Children's Hospital 17th St. at Livingston Park	258-9783

Amendments to Constitution and Bylaws

Constitution

ARTICLE I—TITLE AND DEFINITION

The name of this organization is the Indiana State Medical Association. It is the federacy of Indiana county medical societies.

ARTICLE II—PURPOSES

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the state of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to promote friendly relations among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care and public health so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III—COMPONENT SOCIETIES

Component societies are those county and district medical societies contained within the state of Indiana, and who hold charters from this Association.

ARTICLE IV—MEMBERS

The Indiana State Medical Association is composed of individual members of county medical societies and others as shall be provided in the Bylaws.

ARTICLE V—HOUSE OF DELEGATES

The legislative and policy-making body of the Association is the House of Delegates composed of elected representatives and others as provided in the Bylaws. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in the Constitution and Bylaws and shall elect the general officers, except trustees, as otherwise provided in the Bylaws.

ARTICLE VI—OFFICERS

The general officers of the Association shall be a president, president-elect, immediate past president, [executive director,] treasurer, assistant treasurer, speaker, vice speaker, and the trustees. Their qualifications and terms of office shall be provided in the Bylaws.

ARTICLE VII—TRUSTEES

The Board of Trustees is composed of trustees and alternate trustees elected by the component district medical societies, and the president, the president-elect, treasurer, immediate past president, the assistant treasurer, with power to vote only in the absence of the treasurer, and the speaker and vice speaker without power to vote and the executive director without power to vote. The alternate trustees have power to vote only in the absence of the trustee.

ARTICLE VIII—THE CONVENTION

The House of Delegates and the general scientific program shall be convened annually and at such other times as deemed necessary or as provided in the Bylaws, in cities recommended by the Board of Trustees and approved by the House of Delegates.

ARTICLE IX—FUNDS, DUES AND ASSESSMENTS

Funds may be raised by annual dues or by assessment of the active members on recommendation of the Board of Trustees or any other manner approved by the House of Delegates. Any change in dues or any assessment must be approved by the House of Delegates.

ARTICLE X—AMENDMENTS

The House of Delegates may amend this Constitution at any convention provided the proposed amendment shall have been introduced at the preceding annual convention and provided two-thirds of the voting members of the House of Delegates vote approval and provided that it shall have been published twice during the year in *The Journal* of the Association.

Bylaws

DIVISION ONE—MEMBERSHIP

CHAPTER I—QUALIFICATIONS, ELECTION AND RIGHTS

Section 1. Regular Member. The term "regular mem-

ber" as used in these Bylaws shall include Active, Senior, Military Service Member, Public Health Service Member, Disabled Member, Medical Student Member, Interns and Residents, of component county medical societies who hold the degree of Doctor of Medicine or Bachelor

of Medicine, or who hold an unrestricted license to practice medicine and surgery. As to Interns and Residents they shall be serving in training programs approved by the Association, or if a Medical Student they shall be enrolled in a medical school approved by the Association. All regular members are entitled to exercise the rights of membership in their county and state associations, including the right to vote and hold office, as determined by their respective county medical society and/or their state association.

A *regular member* who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Section 2. Special Member. The term "special member" as used in these Bylaws, unless otherwise indicated, shall mean Associate Members and Honorary Members as defined in Section 3, Chapter I of the Bylaws of the Indiana State Medical Association. Special members shall not be entitled to vote or hold office in this association.

Section 3—Members by Category

A. *Active Members.* The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the district medical society and in the Indiana State Medical Association.

[B. *Associate Members.* Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.]

B. *Interns and Residents.* Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association.

C. *Senior Members.* Senior Members shall be eligible for Senior Membership on January 1 following their 70th birthday and they shall be physicians of the State of Indiana and who have held their membership in the Indiana State Medical Association for 20 years or more; or who have held membership in the Indiana State Medical Association or in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined total of 20 years or more, and who, upon their application, have been certified to the Executive Director as eligible for such membership by the county societies of which they are members. It shall be the duty of the county medical society to verify, through the office or offices of any other state organization or organizations, the fact of membership therein when such membership is claimed as part compliance with the eligibility requirement of 20 years of membership.

D. *Honorary Members.* Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold elective office. They shall not be required to pay membership dues in

the State Association. Such honor may be conferred by the vote of the House of Delegates.

E. *Disabled Members.* Disabled members shall consist of physicians of the State of Indiana who are certified by a member physician to be permanently disabled and no longer able to practice medicine and who continue to reside in the State of Indiana. Proof of permanent disability shall be by notification to the Executive Director of the Association by the secretary of the county medical society in which such permanently disabled physician holds membership.

All such disabled members shall receive membership cards and THE JOURNAL of the Association without charge.

F. *Distinguished Members.* Active members who have fulfilled the American Medical Association's Physician Recognition Award requirements of 150 hours for three years of continuing medical education as a minimum shall be designated as Distinguished Members.

G. *Military Service Members and Public Health Service Members.* Any physician who is actively engaged in the military service or public health service shall be eligible for membership in the Association with payment of reduced dues; they shall receive THE JOURNAL.

H. [Retired] Members who have chosen voluntary *inactivity* [retirement] from the practice of medicine before the age of 70 shall only be required to pay membership dues in the amount of one half of full membership dues applicable at the time [of retirement.]

I. *Student Members.* Medical students who attend an accredited medical school in Indiana. [Students who hold active membership in the Indiana Chapter of the American Medical Student Association.]

Student members[hips] may be represented in the House of Delegates with [all the rights and privileges and] the power to vote. They shall be entitled to send one delegate or one alternate [who are members of the Indiana Chapter of the American Medical Student Association]. Student delegate and alternate are to receive THE JOURNAL of the State Association.

Section 4—Rights and Privileges of Members

A. Suspension or Revocation of License

No person whose license to practice medicine has been suspended or revoked or who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association or of a component county society, nor shall he be permitted to take part in any of their proceedings until he has been relieved of such disability.

B. Attendance at Annual Convention

Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

C. Rights and Privileges by Membership Category

Rights and Privileges of Members. Active members, intern and resident members, senior members, military service members, public health service members, disabled members, honorary members, student members and *inactive* [retired] members shall have the same rights and privileges except as follows:

(a) Senior members shall not be required to pay membership dues in the State Association.

(b) If senior members desire to receive THE JOURNAL of the State Association, they shall pay the

regular subscription price therefor.

(c) Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 1, Chapter XVI of the Bylaws for this coverage.

CHAPTER II—DUES, FUNDS AND ASSESSMENTS

Section 1—Dues

A. Income and Expenses

Funds for carrying on the activities of this Association shall be raised by the following means:

(a) Membership dues to be collected may be collected by the Indiana State Medical Association or by the component county societies. The amount of dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

(b) Voluntary contributions.

(c) Revenues derived from the Association's publications.

(d) Upon recommendation of the Board of Trustees or any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Board for approval before final action is taken thereon.

B. Change in Dues Structure

The final vote on any issue calling for changes in dues or in dues structure shall be by roll call vote of the House of Delegates. Each member's vote shall be permanently recorded and no suspension of this rule will be allowed on the final vote on such an issue.

DIVISION TWO— ANNUAL CONVENTION ACTIVITIES

CHAPTER III—CONVENTION AND MEETINGS

Section 1—Annual Convention

The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Section 2—Selection of Site

The House of Delegates shall select the place five years in advance for holding the Annual Convention. The time for the convention shall be fixed by the Board, and the Board shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Any of the component member county societies wishing to invite the Indiana State Medical Association to hold its annual meeting in its locality shall submit an invitation in writing at least five years in advance to the Board of Trustees. The Board of Trustees shall make an investigation of the facilities and in turn recommend the location to the annual meetings for concurrence by the House.

Section 3—Special Meetings

Special meetings of either the Association or the House of Delegates shall be called by the President upon receipt of a petition signed by thirty delegates or one hundred members. The signed petition shall contain the names of at least ten delegates or thirty-four members from each of at least three Board districts. Upon receipt by the President of such a petition, the President shall

within thirty days thereafter issue a call for such special meeting at a time and place to be fixed by the President. The President, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made.

Section 4—General Meetings

General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Commission on Convention Arrangements, with the sanction and approval of the officers.

Section 5—Appointment of Committees

The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Section 6—Scientific Papers

All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Director when read.

Section 7—Appropriations

The Board of Trustees shall appropriate from the funds of the Association such an amount as in the discretion of the Board shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Commission on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

CHAPTER IV—SPECIALTY SECTIONS

Section 1—Official Sections

During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

- a. Surgical.
- b. Internal Medicine.
- c. Eye, Ear, Nose, and Throat.
- d. Anesthesia.
- e. Family Physicians.
- f. Obstetrics and Gynecology.
- g. Preventive Medicine and Public Health.
- h. Radiology.
- i. Nervous and Mental Diseases.
- j. Pathology and Forensic Medicine.
- k. Pediatrics.
- l. Directors of Medical Education.
- m. Cutaneous Medicine.
- n. College Health Physicians.
- o. Interns and Residents.
- p. Allergy.
- q. Urology.
- r. Orthopedic Surgery.
- s. Emergency Medicine.

Any other sections that hereafter may be provided for

by the House of Delegates. All proposed sections will be formed by properly constituted resolution which shall include the signatures of a minimum of 15 members or 25% of the members, whichever is greater, who are practicing that specialty in the state of Indiana.

Section 2—Officers

The officers of each section shall be a chairman, a vice-chairman, and a secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Section 3—Officer Elections

The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Section 4—Restriction on Meetings

No section meeting shall be allowed to conflict with a general meeting.

DIVISION THREE— BUSINESS AND LEGISLATION

CHAPTER V—HOUSE OF DELEGATES

Section 1—Composition

The House of Delegates shall be the legislative and policy-making body of the Association and shall consist of (1) Delegates, or their designated alternates, elected by the component county societies; (2) the Trustees, or their designated alternates, and (3) the ex-presidents of the Indiana State Medical Association. The delegate or their designated alternate delegate elected by their respective section shall also be a member but without power to vote. The following shall be *ex officio* members: The President, the President-Elect, the Executive Director, the Treasurer and Assistant Treasurer of this Association, the Speaker, the Vice Speaker and the delegates to the American Medical Association, all without power to vote, except the Speaker and Vice-Speaker who shall vote as set forth in Chapter VI, Section 3 (F) and (G) hereafter.

Section 2—Meetings

The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the general or section meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program. Nominations for officers of the Association may be made at any meeting of the House of Delegates.

Section 3—House Admission

All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation.

Section 4—Delegate Apportionment

Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who

shall be selected by the physicians residing in such county. [One delegate and one alternate shall be selected by the Indiana Chapter of the American Medical Student Association.] The student delegate shall be seated with full power to vote. In the absence of the student delegate, the alternate shall be seated with full power to vote.

The number of delegates to which each component society is entitled shall be based upon the number of members on record in the office of the Executive Director in good standing with current dues fully paid as of December 31 of the preceding year.

All sections listed in Chapter III, Section 1, of these Bylaws shall be entitled to send to the House of Delegates each year one delegate or one alternate delegate without the power to vote.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Director of this Association on or before February 1, prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credential card as a delegate or alternate, properly signed by the secretary of his county medical society, executive secretary or executive director of the larger societies, is presented to the Committee on Credentials at the time of the Annual Convention.

Section 5—Quorum

Fifty (50) delegates shall constitute a quorum.

Section 6—Responsibilities

A. Delegates to American Medical Association

The House of Delegates shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

B. Organizing Districts and Sections

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Trustee District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Trustee districts shall be defined by the House of Delegates.

The House shall divide the state into Trustee districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

C. Authority to Appoint Special Committees

The House shall have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

Section 7—Resolutions and Proposals

The House of Delegates shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Proposals calling for appropriations of funds by the House of Delegates shall be accompanied by a fiscal note and shall be submitted to the Executive Committee and the Board for review, presentation and recommendation for final action of the House. No proposal calling for appropriations shall be considered if not accompanied by a fiscal note.

All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Director of the Association so that he will receive them not later than 45 days prior to the meeting

of the House of Delegates to which the resolutions will be presented for action.

Provided, that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Director more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reasons why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the By-laws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Section 8—Reference Committees and Committee on Rules and Order of Business

A. Reference Committees

Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the Speaker with the assistance of the President. The chairman of each committee shall also be appointed by the Speaker with the assistance of the President and they shall also appoint such additional House committees as the House may approve. All committees hereunder shall serve only during the convention at which they are appointed. Appointments shall be made in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The Speaker with the assistance of the President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of at least five members, unless otherwise provided. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except matters as properly come before the Board, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

B. Responsibilities of Reference Committees

Four or more Reference Committees designated by numerals are hereby constituted to which all matters shall be referred, at least one of which shall be organized for the sole purpose of studying the addresses of the president; president-elect; report of the Executive Director; and chairman of the Board of Trustees. This committee shall be mandated to translate recommendations made by these officers through resolutions for presentation to the House.

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the [President] Speaker of the House, be made (a) to as many reference committees as are necessary to cover all subjects included therein; or (b) to only one reference committee which the [President] Speaker deems has within the scope of its reference the most important part of the matter referred.

No report of any reference committee shall be rejected on the ground that it covers something not included in the matters which such committee was created to consider.

C. Time and Place of Meetings

The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

D. Committee on Rules and Order of Business

The Committee on Rules and Order of Business shall be composed of the chairmen of the various Reference Committees appointed by the Speaker.

Section 9—Election of Officers

The officers of this Association with the exception of the Executive Director shall be elected by the House of Delegates as the first order of business at the final meeting of the House of Delegates, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

The officers, except [the Trustees and] the Executive Director [whose election has been provided for elsewhere herein,] shall be elected annually. All officers shall serve until their successors are elected and installed.

A. Method of Election

All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

B. Terms

The President, President-elect, Speaker, Vice-speaker, Treasurer and Assistant Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect, Treasurer and Assistant Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

C. Oath

The officers of the Association shall be installed by taking the following oath of office to be administered by the outgoing President of the Association at the final meeting of the House of Delegates:

I, _____, solemnly swear that I shall carry out to the best of my ability, the duties of the office of the Indiana State Medical Association to which I have been elected.

I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to do the task of bringing increasingly improved medical care within the reach of every citizen.

I shall uphold the Constitution of the United States of America and of the State of Indiana, the Constitution and Bylaws of the American Medical Association and the Constitution and Bylaws of the Indiana State Medical Association at all times.

I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans. To these duties and obligations, I pledge myself, so help me God.

CHAPTER VI—OFFICERS

Section 1—Composition

The officers of this Association shall be a President, a President-Elect, the Immediate Past President, an Executive *Director*, a Treasurer, an Assistant Treasurer, a Speaker, a Vice-Speaker, each of whom shall be a member, except the Executive *Director*, who need not necessarily be either a physician or a member.

Section 2—Removal, Death, Resignation, Vacancy

Any officer may be removed from office after a hearing before the Board, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Board.

In the event of the death, resignation, removal, or disability of the President, the President-Elect shall succeed to the presidency. In the event of the death, resignation, removal, or disability of both the President and the President-Elect, the Chairman of the Board shall become President Pro Tem and shall perform the duties and obligations as set forth in Section 3 of this chapter. As President Pro Tem the Chairman of the Board shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-Elect shall be elected, both of whom shall take office immediately upon their election.

The Board shall fill a vacancy in the office of Treasurer or Assistant Treasurer by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.

Section 3—Duties

A. President

The President, or a member designated by him shall preside at all general meetings of the Association. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Trustees in building up the county societies and in making their work more practical and useful.

B. President-elect

The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties. *Ex officio*, he shall be a member of all commissions and committees.

C. Treasurer

The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Board. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the chairman of the Board. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

D. Assistant Treasurer

The Assistant Treasurer shall give bond at the expense of the Association in such amount as shall be required by the Board unless he is included in the coverage of a blanket or position bond. In case of death, or incapacity of the Treasurer, he shall succeed to all the duties and rights of the Treasurer until a new Treasurer be elected. In the absence of the Treasurer, he shall attend to the duties and rights of the Treasurer during such absence and he shall also perform such duties of the Treasurer as may be delegated and assigned to him by the Treasurer.

E. Executive Director

The Executive *Director* shall be the directing manager of the Association's headquarters and JOURNAL offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Board, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to nonprofessional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Board, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Board.

F. Speaker

The Speaker shall preside at all meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He may address the House of Delegates at the opening meeting of all conventions, limiting his address to matters of conduct and procedure in the House. He is entitled to vote when the vote is by ballot. In all other cases, he shall have the right to vote only in case of a tie.

He shall be elected annually from the membership of the House. *Ex officio*, the Speaker shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Speaker and shall be provided at the expense of the Association.

G. Vice Speaker

The Vice Speaker of the House of Delegates shall officiate at meetings in the absence of the Speaker or at the request of the Speaker. The Vice Speaker shall be elected annually from the membership of the House. *Ex officio*, he shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Vice Speaker and shall be provided at the expense of the Association. In the case of death, resignation or removal of the Speaker, the Vice-Speaker shall officiate during the unexpired term.

H. Expenses

The necessary expenses of the above officers incurred in the line of duty herein imposed shall be allowed for in the budget, but excepting the Executive *Director*, this shall not include the expenses of attending the Annual Convention.

CHAPTER VII—BOARD OF TRUSTEES

Section 1—Composition/Voting Power

The Board of Trustees shall consist of (1) the Trustees with power to vote and their duly elected alternates, each of the latter without power to vote except when the Trustee is not in attendance; and (2) ex officio, the President, President-Elect, Treasurer, Immediate Past President with power to vote, Assistant Treasurer without power to vote except in case the Treasurer is not in attendance, and the Speaker, [and] Vice-Speaker, and Executive *Director* without power to vote.

[Composition. The Board of Trustees shall consist of 22 members, 14 elected as provided in Section 3, Chapter VII, of the Bylaws, and the President, President-Elect, Treasurer and Immediate Past President, Assistant Treasurer, Speaker, Vice-Speaker and the Executive *Director*.]

Section 2—Authority

The Board shall be the executive body of the Association, with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require, and perform and exercise all of the rights and duties as specified in this chapter.

Section 3—Election

Election—Trustee and Alternate. The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee(s) or Alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive *Director* of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Section 4—Meetings and Terms

The Board shall meet as follows: 1. The Board shall meet at least once each quarter of the calendar year, the time, date and location to be fixed by the Board. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the chairman, or on petition of three Trustees. It shall hold no meeting that will conflict with any meeting of the House of Delegates. Notice of each regular meeting shall be given at least ten days before such meeting.

Special meetings may be called at any time by the Chairman or at the request of seven members of the Board. Notice shall be given at least five days before each special meeting. The notice shall specify the general purpose of and business to be transacted at the meeting, [but other business may also be transacted.]

It shall elect a chairman, and a clerk, who, in the absence of the Executive *Director* of the Association, shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Board shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of Trustees shall begin with the first meeting of the Board following the final session of the House of Delegates at the Annual Session.

The term of the elected Trustees shall be for three years and approximately one third of the number shall be elected annually. No Trustee shall be eligible to serve longer than two consecutive three-year terms.

Each Trustee district shall elect an Alternate Trustee whose term of office shall be for three years. The Alternate Trustee shall be elected in a year during which his Trustee is not elected.

Section 5—Vacancies

In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any District Trustee, the duly elected Alternate Trustee from the same district shall succeed to the office of the Trustee in that District for the unexpired term of said Trustee. In the event vacancies occur in any Trustee District in the offices of both Trustee and Alternate Trustee, the vacancies shall be filled by an election by the members of the Association within the Trustee District in which the vacancies occur. A call for such elections shall be issued by the Executive *Director* of the State Association following a conference(s) with the officers of the District organization. The call shall state the time and place of holding the election and shall be sent registered mail to the County Secretary as filed in the State *Director's* Office of each component society within the District. Such call shall be mailed within ten days after the State *Director* has learned of the vacancies. The election may be held at a special or regular meeting at which business other than the election may be transacted. Such election shall be held within fifteen days after the *Director* of the State Association shall have mailed such call.

Section 6—Organization and Duties

A. Immediately following the conclusion of the annual convention, the Board shall organize by electing a Chairman and a Clerk. [Vice-Chairman, Secretary, and Committees necessary to its needs.]

The Board of Trustees at its organization meeting, by resolution adopted by a majority of the Trustees in office, may designate two Trustees or members of the Association to complete the Executive Committee. Members of the Committee shall serve until the next organization meeting of the Board and until their successors are elected and qualified. The Executive Committee shall have such powers and duties as may be defined from time to time by resolution of the Board of Trustees.

B. Quorum

Twelve members of the Board shall constitute a quorum.

C. Attendance at Meetings

If any elected Trustee fails, without reason acceptable to the Board, in any one calendar year to attend a majority of the meetings of the Board, he shall thereby cease to be a Trustee, and the Executive *Director* shall thereupon take action in accordance with Section 5, Vacancies.

D. Meeting Notices

Notice is given if delivered in person, by telephone, mail or telegram. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, addressed to a Trustee (and other persons entitled to notice) at his address then appearing on the records of the Association, with postage prepaid, and if given by telegraph, shall be deemed delivered when the telegram is delivered to the telegraph company.

Notice of any meeting and the object or business to be transacted at a meeting of the Board need not be given if waived in writing, or by telegraph, cable, or wireless before, during, or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting except where attendance is for the express pur-

pose of objecting to the transacting of any business because the meeting is not lawfully called or convened.

E. Business of Association

The Board shall perform all acts and transact all business for or on behalf of the Association and manage the property and conduct the affairs, work and activities of the Association, except as may be otherwise provided in the Constitution or the Bylaws. All resolutions and recommendations of the House of Delegates including the expenditure of funds passed by the House of Delegates, shall be referred to the Board of Trustees which shall determine if the resolutions, recommendations or the expenditures are advisable. If it is decided that the resolution(s), recommendation(s), or the expenditure(s) is inadvisable, the Board shall report, at its earliest convenience, to the House of Delegates the reasons for its action.

F. Journal and Other Publications

The Board shall provide for the publication of and determine the editorial policies, in accordance with the policy enunciated by the House of Delegates, of (1) THE JOURNAL of the State Association, (2) publications as it may deem expedient, (3) a publication for public information and dissemination and (4) all proceedings, transactions and memoirs.

The Board shall provide for and superintend all publications of the Association, and shall appoint an editor and an editorial board, as it deems necessary, and fix the amount of their salaries. The proceedings of the Board for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Appoint an editor or editors for all of the Association's publications.

G. Employ Executive

Employ the Executive *Director*, and fill any vacancy therein, who shall be the person to manage and direct the activities of the Association under the authority granted by the Board.

H. Financial Reports

(1) Have the accounts of the Association audited at least annually.

(2) Make proper financial reports concerning Association affairs to the House at its annual convention.

I. County Visitations, Expenses and Reports

Each Trustee shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Trustee in the line of the duties herein imposed may be allowed by the Board on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

J. Organizing County Societies

The Board shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be

deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly relations among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

K. Scientific Work

The Board shall, through its officers and otherwise, given diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

The Board shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

L. Interests of the Profession

The Board shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

M. Charters

The Board shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

N. Board of Censors

The Board shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Board without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Trustee, and its decision in all such matters shall be final.

O. Election of At-Large Members to Executive Committee

The Board shall at its meeting following the close of the House of Delegates specify the duties and elect two members of the Association, at large, or of the Board, who, with the President, the President-elect, the Immediate Past President, the Treasurer, and the Chairman of the Board, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Board they shall not have the power to vote in the Board.

P. Duties of Alternate Trustee

The duties of the Alternate Trustee shall be:

(a) To represent the Trustee District when the regu-

larly elected Trustee is not in attendance.

(b) To vote only when the Trustee is not in attendance either in the House of Delegates or in the Board meetings where he represents the regularly elected Trustee.

CHAPTER VIII—THE EXECUTIVE COMMITTEE

Section 1—Composition

The Executive Committee, constituted as provided in Chapter VII (R) of these Bylaws, shall hold its first meeting immediately following the meeting of the Board held at the close of the last meeting of the House of Delegates in the Annual Convention, and shall organize by electing its chairman. Its secretary shall be the Executive *Director* of the Association. It shall meet with the Executive *Director* on the call of the chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive *Director's* office and such other duties as the Board may specify. It shall have all jurisdiction with respect to medical defense activities of the Association, and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to THE JOURNAL, during the intervals between the meetings of the Board, and shall report its actions to the Board.

Section 2—Budget Responsibility

It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Section 3—Investment of Surplus Funds

The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Board at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws.

Section 4—Student Loans

The Executive Committee shall have the authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. Rules and regulations adopted shall be subject to the approval of the Board. The Executive *Director* shall have the duty and responsibility of keeping minutes of all transactions and shall file a copy of such minutes, as well as a copy of all papers pertaining to any application or loans, in the Headquarters Office of the Association.

Section 5—Vacancy

A vacancy on the Executive Committee shall be filled by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.

CHAPTER IX—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1—Creation of Committees and Commissions

The organization of the Association, the performance

of which is not provided elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Board or of the House of Delegates, or by special committees created by the Executive Committee, the Board or the House of Delegates, may be performed by the following committees and commissions:

The Grievance Committee

The Future Planning Committee

The Medical Legal Committee

The Commissions are as follows:

COMMISSION ON MEDICAL SERVICES

This Commission encompasses the fields of:

Emergency Medical Services

Aging

Public Health

Governmental Medical Service Programs

Voluntary Health Agencies

Sports and Medicine

Medical Economics and Insurance

COMMISSION ON MEDICAL EDUCATION

This Commission encompasses the fields of:

Licensure

Accreditation

Education Program

COMMISSION ON LEGISLATION

This Commission encompasses the fields of:

State Legislation

Federal Legislation

COMMISSION ON CONSTITUTION AND BYLAWS

COMMISSION ON PUBLIC RELATIONS

This Commission encompasses the fields of:

Public Information

Special Activities

Interprofessional Relations

COMMISSION ON CONVENTION

ARRANGEMENTS

This Commission encompasses the fields of:

Specialty Medicine

(The following Section 2 to be deleted and reference to student loans is provided for in Chapter IX, Section 4)

[Section 2—Student Loan Committee

The responsibilities of the Student Loan Committee are transferred to the jurisdiction of the Executive Committee.]

Section 2—Committee Structure

Except as otherwise stated in the Bylaws, with specific reference to Chapter IX, Section 8A, a Committee shall consist of not less than 4 nor more than 5 members, appointed from the general membership of the Association and shall be appointed annually by the President. The President shall also appoint the Chairman [and the Vice Chairman] of each Committee. *The committee chairman shall appoint a vice chairman.*

Section 3—Commission Structure

Each Commission will consist of 15 members appointed by the President, with at least one member from each Trustee district. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise. The President shall also appoint the chairman [and the vice-chairman] of each commission. *The commission chairman shall appoint a vice chairman.*

Section 4—Removal of Members

The President shall have the power, with the approval of the Board, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Section 5—Terms

Unless otherwise provided in these Bylaws, no member of either a committee or a commission shall serve on the same committee or a commission more than two consecutive terms, but this shall not prevent his serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Section 6—Initial Meeting

Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. In these meetings the commissions may provide for such subcommissions within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Section 7—Coordination of Activities

Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Section 8—Duties and Responsibilities

Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

A. The Grievance Committee

—The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians, and between physicians. It may, if it believes the facts justify such action, cite a member of the Association to the Board of the State Association. It shall, subject to the approval of the Board, draw up a set of rules and regulations governing its procedure and official action.

B. The Future Planning Committee

—The function of this committee shall be to study and anticipate future trends and to stimulate the various

commissions in coordinated directions so there is concord to the entire operation of Indiana State Medical Association. It is not contemplated that it be an operational committee.

C. The Medical-Legal Review Committee

—The Medical-Legal Review Committee shall consist of three members *selected from the Indiana State Medical Association* whose duty it shall be to meet in joint session and work with a similar committee of *three members of the State Bar Association* to be appointed by [the President of] the *Indiana State Bar Association*. [This committee] *These three members* of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in that Code in the form in effect from time to time as approved by the Association, and in all other medical-legal matters.

D. The Commission on Medical Services

—The Commission on Medical Services shall concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military manpower, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the government, plans and programs of the government for medical care now existing or which may hereafter be adopted by any special group, government programs for elimination of venereal disease and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments.

E. The Commission on Medical Education

—The Commission on Medical Education shall maintain liaison with, and try to be of assistance to, medical schools and the licensing board; and shall keep in contact with, and endeavor to assist in improving, undergraduate education, postgraduate education, intern training, resident training, preceptor instruction, and public school health education.

F. The Commission on Legislation

—The Commission on Legislation shall study all legislation, both state and national, and all local legislative trends and movements, as to their effect upon the practice of medicine and the protection of the public health; shall keep the profession informed at all times concerning the matters within its area of responsibility; shall conduct investigations of legislative proposals; and shall maintain liaison with members of the State Legislature and the United States Congress, and with the legislative activities of the American Medical Association. It shall strive to implement and make effective the legislative proposals adopted by the Association.

G. The Commission on Constitution and Bylaws

—The Commission on Constitution and Bylaws shall keep in contact with the developments and changes in procedures in carrying on the work of this Association; shall suggest revisions necessary to keep the Constitution and Bylaws always in accord with the practices and procedures best adapted to the functioning of the Association; and shall keep the practices and procedures of the

Association consistent with the provisions from time to time contained in the Constitution and Bylaws—to the end that all members of the profession, by reference to the Constitution and Bylaws, may be able to obtain accurate information regarding procedure and practice within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and Bylaws may be avoided.

H. The Commission on Public Relations

—The Commission on Public Relations shall collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including also the achievements in the advancement of medicine which would be of interest to the public; shall disseminate all such information through the use of whatever media the commission may find adaptable to that purpose so that such information may be brought to the public in the most effective and convincing manner; and shall develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

I. The Commission on Convention Arrangements

—The Commission on Convention Arrangements, with the advice and assistance of the Executive *Director*, shall provide suitable accommodations for meetings of the Association, including the House of Delegates, Board, and of their respective committees, the scientific and and technical exhibits, and in conjunction with the Executive *Director*, shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive *Director* of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

—It shall, with the approval of the Executive Committee, prepare a program for scientific work for the Annual Convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the officers [on] of the various sections; and it shall, with the approval of the Executive Committee, arrange for scientific exhibits as a part of the Annual Convention.

—The general, scientific and sectional programs, and the financial arrangements to provide for them must be approved by the Executive Committee before being officially announced.

Section 9—Ex Officio Members

The President, *President-elect*, Executive *Director*, Speaker and Vice-Speaker of the House shall be ex officio members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

CHAPTER X—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of reelection.

CHAPTER XI—REFERENDUM

Section 1—Procedure

A general meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

CHAPTER XII—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

DIVISION FOUR— COUNTY AND DISTRICT SOCIETIES

CHAPTER XIII—COUNTY SOCIETIES

Section 1—Charters

—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and Bylaws and other rules and resolutions of this Association.

—Charters shall be issued only upon approval of the Board and shall be signed by the President and Executive *Director* of this Association. The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Trustee for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Board, which shall decide what action shall be taken.

Section 2—Membership Qualifications

—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine, a degree of Bachelor of Medicine or who holds a valid, unrestricted license to practice medicine and surgery, and who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be eligible for membership. Provided, however, that each county society may deny membership in such society for infraction or violation of any law relating to the practice of medicine or of the Constitution and Bylaws of such society, the Constitution and Bylaws of the Indiana State Medical Association or for a violation

of the Principles of Medical Ethics of the Indiana State Medical Association; and may, after due notice and hearing, censor, suspend or expel any member for any such infraction. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Section 3—Right of Appeal

—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Board, and its decision shall be final.

—In hearing appeals the Board may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Trustees in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Section 4—Membership Transfer

—When a member in good standing in a component society moves to another county in this state, his name shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the transfer is proposed.

—A physician who has the major part of his practice in a county other than the county in which he resides may hold his membership in the county society of his residence or in the county society of the county in which he has the major part of his practice. However, no physician shall hold active membership in more than one county society at the same time.

Section 5—Direction of Profession

—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Section 6—Selection of Delegates

—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Director of this Association annually on or before February 1.

Section 7—Secretarial Duties

—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Trustee of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report

to the Trustee shall also be sent to the Executive Director of the State Association. The State Association shall supply each county secretary a form for these reports.

Section 8—Fiscal Year and Dues

—The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. The dues shall be collected by the calendar year and payable in advance.

Unless collected by the Indiana State Medical Association, the secretary of each component society shall forward the dues for his society to the Executive Director of this Association and shall furnish the State Association Headquarters with a roster of officers, members and a listing of non-affiliated physicians of the county, on or before January 1 of each year, and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Director of this Association the dues for such members.

The dues and the rights and benefits of all members shall be as provided in Chapter I, Section 1, et seq. of the bylaws.

[The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only.] Provided, however, that physicians elected to their first membership in this Association during the first six months of any year shall pay the regular annual dues for that year; and those elected to their first membership after July 1 of any one year shall pay fifty percent of the annual dues as dues for the remainder of that year. Interns and residents shall pay annual dues during their term of service in the hospital at a reduced rate established by the Board of Trustees.

In the event the county society relieves a member from the payment of dues on account of financial hardship, the secretary of the county medical society shall recommend in writing to the Trustee of his district the relief from State Association dues of said member of the society, showing why such recommendation should be granted. The Trustee in turn shall present the recommendation to the Board, which shall have the power to relieve a member of dues.

Section 9—Failure to Pay Dues

—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 10—Secretary Direction

—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Section 11—Constitution and Bylaws

—Each component society shall have its own Constitution and Bylaws, which shall not be in conflict with the Constitution and Bylaws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive Director of the Indiana State Medical Association not later than May 1 of each calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive Director.

CHAPTER XIV—

TRUSTEE DISTRICT MEDICAL SOCIETIES

Section 1—Composition

—A Trustee District Medical Society, hereinafter called the district society, shall be a society whose members consist of the members of the county medical societies in the counties which constitute the Trustee district.

Section 2—Number of Districts

—The state shall be divided into thirteen (13) Trustee districts with the boundary lines and numbers of each district to be as follows:

First District—Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson Counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan Counties.

Third District—Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence Counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Bartholomew and Brown Counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam Counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock Counties.

Seventh District—Morgan, Johnson, Marion and Hendricks Counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford Counties.

Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton, White, Newton and Jasper Counties.

Tenth District—Porter and Lake Counties.

Eleventh District—Carroll, Howard, Grant, Huntington, Wabash, Miami, and Cass Counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben Counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart Counties.

Section 3—Constitution and Bylaws

—Each district society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the State Association, and only one district society shall exist within any one Trustee district. The authorized district society in each Trustee district shall receive a charter from the State Association, and the secretary of the district society shall have custody of the charter.

Section 4—Officers

—Each district society shall organize by electing a president, a secretary and a treasurer and Trustee(s) and Alternate Trustee(s) as the current Trustee(s) term and Alternate Trustee(s) term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of secretary and treasurer may be held by the same physician. The Trustee(s) shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

Section 5—Trustee Allocation

—Each district society shall have one Trustee and one Alternate Trustee for each 600 active members or major fraction thereof but in any event each district shall have one Trustee and one Alternate Trustee. The term of each trusteeship newly created by the numerical growth of a district shall begin at the organization meeting of the Board immediately following the adjournment of the second meeting of the House of Delegates at the next annual meeting, in accordance with Chapter VII, Section 6A.

Section 6—Dues

—The dues of the district society, in an amount fixed by the district society to meet the society needs, shall be collected by the secretaries of the component county societies, or by the Indiana State Medical Association and delivered to the treasurer of the district society. The secretary of each district society shall report to the office of the Indiana State Medical Association the names and addresses of the members of his district society, together with a copy of the minutes of each meeting of his district society.

Section 7—Meetings

—Each district society shall meet at least once each year at a time and place to be fixed by the district society. On or before January 1 of each year each district society shall notify the headquarters of the State Association of the time and place of the annual district meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Board, the Trustee shall fix the time and place of the district meeting, and notice of such meeting shall be sent to the members of the county medical societies in such district.

Section 8—Notification to Headquarters

—Whenever a district society is to elect a Trustee and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such district society not later than the first of March of the year in which the election is to occur.

—The district society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the district of the meeting at least thirty (30) days prior to the date thereof.

Section 9—Election to Blue Shield

—It shall be the duty of each district medical society to select in any manner it chooses a member from its district to serve a term or fill an unexpired term on the Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield). Notice of such selection shall be immediately transmitted to the Board of Trustees of the Indiana State Medical Association which will officially place said selected member in nomination for election to said Board of Directors.

Any member selected or nominated to serve on the Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) may serve an unlimited number of three year terms as approved by his constituent county medical societies. The Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) should prepare a list of needed qualifications for nomination to this office.

DIVISION FIVE—MEDICAL DEFENSE CHAPTER XV—MEDICAL DEFENSE ADMINISTRATION, AUTHORITY AND PROCEDURES

Section 1—Dues Allocation

—One dollar and twenty-five cents (\$1.25) out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Section 2—Administration

—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Section 3—Authority

—This committee shall have full authority governing all matters pertaining to this Chapter. In order to insure

a fair and full presentation of defense for any member physician sued or against whom claim is made, the committee shall have the power to employ and pay an attorney of their choice as a consultant to the committee, and such other expenses as the committee may approve as necessary. It is expected that the committee's consultant attorney will provide necessary communication with the member-physician's personal attorney.

Section 4—Custodian of Funds

—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the chairman of the Board.

Section 5—Annual Report

—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Section 6—Liability

—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these Bylaws.

Section 7—Eligibility

—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Director, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services, which are the basis of the suit, were rendered.

Section 8—Filing for Defense

—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Director of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the president, secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Section 9—County Society Committee

—The committee of the county medical society shall

immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Section 10—Appeal

—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Section 11—Deceased Member

—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Section 12—Locality Restrictions

—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Section 13—Adoption of Rules

—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Section 14—Terms of Defense

—Medical defense as provided for by this Association shall be available to members under the terms stated in these Bylaws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

DIVISION SIX—MISCELLANEOUS

CHAPTER XVI—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XVII—PARLIAMENTARY PROCEDURE

—The deliberations of this Association shall be governed by parliamentary usage as prescribed in the current edition of Sturgis Standard Code of Parliamentary Procedure, when not in conflict with this Constitution and Bylaws.

CHAPTER XVIII—AMENDMENTS

Section 1.—These Bylaws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and Bylaws all previous Constitutions and Bylaws are hereby repealed.

CHAPTER XIX—MEDICAL ETHICS

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Principles of Medical Ethics of the American Medical Association

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only

after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the equality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

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Deaths of Indiana Physicians in 1976

(M) Member ISMA

(S) Senior Member

(R) Retired

Name	Age	Date of Death	Address	Cause of Death
Hepner, Herman S. (S)	80	Jan. 5	Bloomington	Malignant melanoma with metastasis
Otten, Claude F. (M)	65	Jan. 11	Indianapolis	Cerebral thrombosis
Navarre, Vincent J. (M)	54	Jan. 12	Munster	Aplastic anemia
Lavengood, Russell W. (S)	77	Jan. 20	Marion	Acute myocardial infarction; arteriosclerotic cardiovascular disease
Rudolph, Carl J.	70	Jan. 21	Fort Pierce, Fla.	Perforated peptic ulcer
Huckleberry, Irvin E. (S)	82	Jan. 23	Salem	Carcinoma of prostate with cerebral metastasis
Bowers, Gah T. (M)	70	Feb. 1	Fort Wayne	Pneumonia
Beeler, Raymond C. (S)	88	Feb. 2	Indianapolis	Heart disease
Turner, Harold B. (S)	85	Feb. 3	Bloomfield	Cerebral hemorrhage, iron deficiency anemia; arteriosclerotic C-V disease
Smith, Gloster Jerome	58	Feb. 16	Kokomo	Pulmonary embolism
Loudermilk, Richard G.	40	Feb. 19	Fort Wayne	Myocardial infarction
Desjean, Paul A. (M)	69	Feb. 21	Pompano Beach, Fla.	Intestinal hemorrhage due to cirrhosis
Schuchman, Gabriel (M)	58	Feb. 23	Indianapolis	Myocardial infarction
Lee, John Moffett (S)	93	Feb. 26	Rushville	Acute myocardial infarction
McIndoo, Ralph E. (S)	85	Feb. 26	Kokomo	Cerebral hemorrhage
Klepfer, Jefferson F.	70	Feb. 29	Richmond	Bronchopneumonia
Stouder, Albert E. (M)	64	Mar. 1	Kempton	Cardiac arrest; atherosclerotic and hypertensive heart disease
Hare, Earl H. (S)	85	Mar. 2	Indianapolis	Possible pulmonary embolus
Young, George M. (S)	72	Mar. 2	Griffith	Acute coronary artery occlusion; hypertensive arteriosclerotic heart disease
Leschot, Kenneth R.	30	Mar. 5	Evansville	Myocardial infarction
DeWees, Dwight L. (S)	74	Mar. 15	Indianapolis	Coronary occlusion; arteriosclerotic heart disease
Jordan, Leo E. (M)	71	Mar. 22	Lynn	Acute coronary insufficiency
McGue, Frank J. (M)	50	Mar. 24	Cartersville, Ill.	Cardiogenic shock
McIlwain, Eleanor Harper	76	Mar. 31	Culver	Cerebral hemorrhage; bone marrow failure
Kleindorfer, Roscoe (S)	77	Apr. 11	Evansville	Cerebral hemorrhage; arteriosclerosis; diabetes mellitus
Brockmole, Arnold W. (M)	59	Apr. 15	Evansville	Myocardial infarction
Cole, Ira (S)	85	Apr. 21	West Lafayette	Pneumonia
Taraba, Ralph Waldo (M)	59	Apr. 25	Bloomington	Cerebro vascular accident; hypertension
Emme, Richard Wayne (M)	61	Apr. 25	Fort Wayne	Malignant melanoma
Peck, Edward A.	65	Apr. 25	Hammond	Cardiac arrhythmia; infarction, myocardium; arteriosclerotic heart disease
Ross, James B.	45	Apr. 28	Bloomington	Coronary occlusion; arteriosclerotic heart disease
Loudermilk, Jack L. (M)	61	May 1	Tempe, Ariz.	Carcinoma of the lung
Pierson, Howard W., Jr. (M)	56	May 1	Gary	Acute subarachnoid hemorrhage; ruptured anterior communicating artery aneurism—congenital type
Stork, Harvey K. (S)	84	May 1	Huntingburg	Uremia; arteriosclerotic degenerative disease generalized with cardiac insufficiency
Hill, Robert E. (S)	71	May 14	Yorktown	Coronary occlusion; arteriosclerotic heart disease
Toumey, Fred L. (M)	62	May 14	Indianapolis	Cerebral thrombosis; generalized arteriosclerosis
Matthews, Bernard J. (S)	76	May 17	Indianapolis	Acute myocardial infarction; coronary artery insufficiency
Leming, Ben L. (M)	58	May 30	Fort Wayne	Drug overdose
Wrege, Malcolm L. (M)	52	June 7	Indianapolis	Pulmonary insufficiency; carcinoma of lung
Overshiner, Lyman (S)	89	June 16	Columbus	Bronchial pneumonia; influenza virus

Campbell, Sam W. (M)	56	June 19	New Castle	Apparent myocardial infarction
Martin, Paul Herbert (M)	76	June 20	Elkhart	Uremia; carcinoma of urinary bladder, invasive
Wyatt, James Louis III	60	June 23	Fort Wayne	Acute myocardial infarction
Foster, Robert H. K. (S)	74	July 18	Franklin	Pneumonia; stroke; arteriosclerosis, cerebral
Mehne, Richard G. (M)	50	July 21	Brazil	Acute myocardial infarction; arteriosclerotic heart disease
Dyer, Wallace K. (M)	63	Aug. 3	Evansville	Congestive heart failure; ventricular fibrillation; ischemic cardiomyopathy
Nugent, Edwin J. (S)	73	Aug. 10	Indianapolis	Pneumonia; aspiration; Parkinson's disease
Donahue, Francis E. (M)	56	Aug. 18	New Castle	Cardiorespiratory failure; thermal burns approximately 70% total body space
Mittleman, Edwin J.	76	Aug. 21	Mishawaka	Carcinomatosis (chest)
Sennett, William K. (S)	73	Aug. 22	Macy	Acute pulmonary and cardiac failure
Jolly, Lewis Everett, Sr.	64	Aug. 23	Hanover	Gastrointestinal hemorrhage with massive blood loss
Scales, Alfred Blythe (S)	78	Aug. 24	Huntingburg	Cardiopulmonary failure; renal failure; advanced generalized arteriosclerotic vascular disease
McDonald, Virgil G. (S)	90	Aug. 25	Anderson	Pulmonary edema; arteriosclerotic heart disease
Dunning, Thomas W. (M)	47	Aug. 29	Muncie	CO ₂ asphyxiation (66.2%); fire at residence
Sabina, Robert E. (M)	42	Aug. 31	Munster	Asphyxia (drowning)
Moses, George E. (S)	79	Sept. 15	Worthington	Metastatic oat cell carcinoma, right lung
Nixon, Byron (S)	79	Sept. 23	Farmland	Acute cardiac arrest; arteriosclerotic heart disease
Haller, Thomas C.	68	Sept. 24	Crawfordsville	Ventricular tachycardia
Werry, Leslie Edward (S)	92	Sept. 25	Hartford City	CVA; cerebral arteriosclerosis
Springstun, Charles Leland	77	Sept. 26	Chrisney	Pneumonia
Clark, Ivan A. (S)	71	Oct. 3	Paoli	Metastatic carcinoma lung
Baxter, John P. (M)	50	Oct. 20	Carmel	Cause undermined; presumed gastric aspiration; ethanol intoxication
Parker, Carey B. (S)	81	Oct. 21	Fort Wayne	ASCVD—stroke
Van Dorn, Myron J. (M)	60	Oct. 27	Indianapolis	Liver coma; cirrhosis of liver; anemia due to ruptured blood vessel of esophagus
Scott, Robert O. (M)	64	Oct. 30	Nineveh	Cardiopulmonary arrest; carcinoma of lung
Sutton, William E. (M)	67	Nov. 1	Indianapolis	Acute respiratory failure; cerebrale degeneration; arteriosclerosis
Williams, Fred	57	Nov. 3	Gary	Intracerebral hemorrhage in bilateral basal ganglia; cerebral arteriosclerosis and hypertension
Kay, Oren E. (S)	82	Nov. 5	Spencer	Pulmonary embolus; cholecystitis
Todd, David D. (S)	94	Nov. 5	La Jolla, Calif.	
Oliphant, Frank W. (R)	63	Nov. 7	Cadiz, Ky.	
Glass, Robert Lee	76	Nov. 9	Muncie	Acute cardiovascular failure; atherosclerotic heart disease
Griffith, Ross E. (M)	66	Nov. 13	Indianapolis	Arteriosclerotic heart disease
Boswell, Robert (M)	66	Nov. 16	Evansville	Coronary artery disease with myocardial infarction
Berman, Jacob Kohn (S)	80	Nov. 17	Indianapolis	Cardiac arrest; arteriosclerosis
Chang, Marge L.	33	Nov. 22	Indianapolis	Extensive cranio-spinal and cerebral injuries (car-train accident)
Wildman, Roscoe E. (R)	82	Dec. 1	Peru	Acute pulmonary edema; cardiac decompensation; arteriosclerotic heart disease
Carter, Richard Lloyd	33	Dec. 7	Valparaiso	Asphyxia; carbon monoxide poisoning; self ingestion
Rosales, Marina N.	43	Dec. 12	Munster	Carcinoma of breast
Armington, Charles L. (S)	72	Dec. 13	Anderson	Sarcoma, stomach; unclassified
Schlosser, Herbert C. (S)	82	Dec. 16	Elkhart	Bronchopneumonia; CVA—hemiplegia, left; chronic brain syndrome, arteriosclerotic
Nelson, Audrey H.	49	Dec. 17	Indianapolis	Carcinoma of ovary with metastases
Heck, Martin C. (M)	68	Dec. 19	Jasper	Respiratory arrest; chronic obstructive lung disease
Torella, Jose A. (M)	68	Dec. 19	Speedway	Congestive heart failure; cardiomyopathy, idiopathic
Aronson, Sidney S. (S)	77	Dec. 31	Indianapolis	

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				*William F. Howat, Hammond	1911 1912
Medical Society				*A. C. Kimberlin, Indianapolis	1912 1913
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*George W. Mears, Indianapolis	1851	1852		*George F. Keiper, Lafayette	1915 1916
*Jeremiah H. Brower, Lawrenceburg	1852	1853		*John H. Oliver, Indianapolis	1916 1917
*Elizur H. Deming, Lafayette	1853	1854		*Joseph Rilus Eastman, Indianapolis	1917 1918
*Madison J. Bray, Evansville	1854	1855		*William H. Stemm, North Vernon	1918 1919
*William Lomax, Marion	1855	1856		*Charles H. McCully, Logansport	1919 1920
*Daniel Meeker, LaPorte	1856	1857		*David Ross, Indianapolis	1920 1921
*Talbot Bullard, Indianapolis	1857	1858		*William R. Davidson, Evansville	1921 1922
*Nathan Johnson, Cambridge City	1858	1859		*Charles H. Good, Huntington	1922 1923
*David Hutchinson, Mooresville	1859	1860		*Samuel E. Earp, Indianapolis	1923 1924
*Benjamin S. Woodworth, Ft. Wayne	1860	1861		*Eldridge M. Shanklin, Hammond	1924 1925
*Theophilus Parvin, Indianapolis	1861	1862			
*James F. Hibberd, Richmond	1862	1863		Medical Association	
*John Sloan, New Albany	1863		*Charles N. Combs, Terre Haute	1925 1926
*John Moffett (acting), Rushville	1863	1864		*Frank W. Cregor, Indianapolis	1926 1927
*Samuel L. Linton, Columbus	1864		*George R. Daniels, Marion	1926 1928
*Wilson Lockhart (acting), Danville	1864	1865		*Charles E. Gillespie, Seymour	1927 1929
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*Samuel S. Boyd, Dublin	1876	1877		*Maynard A. Austin, Anderson	1940 1942
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*Jacob R. Weist, Richmond	1879	1880		*Jesse E. Ferrell, Fortville	1944 1946
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*James S. Gregg, Ft. Wayne	1885	1886		*J. William Wright, Indianapolis	1950 1952
*General W. H. Kemper, Muncie	1886	1887		*Paul D. Crimm, Evansville	1951 1953
*Samuel H. Charlton, Seymour	1887	1888		*Wm. Harry Howard, Hammond	1952 1954
*William H. Wishard, Indianapolis	1888	1889		*Walter L. Portteus, Franklin	1953 1955
*James D. Gatch, Lawrenceburg	1889	1890		*Walter U. Kennedy, New Castle	1954 1956
*Gonsolvo C. Smythe, Greencastle	1890	1891		*Elton R. Clarke, Kokomo	1955 1957
*Edwin Walker, Evansville	1891	1892		M. C. Topping, Terre Haute	1956 1958
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*Walker Schell, Terre Haute	1899	1900		Eugene S. Rifner, Van Buren	1965 1967
*George W. McCaskey, Ft. Wayne	1900	1901		*G. O. Larson, LaPorte	1966 1968
*Alembert W. Brayton, Indianapolis	1901	1902		Patrick J. V. Corcoran, Evansville	1967 1969
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*George H. Grant, Richmond	1905	1906		James H. Gosman, Indianapolis	1971 1973
*George J. Cook, Indianapolis	1906	1907		Joe Dukes, Dugger	1972 1974
*David C. Peyton, Jeffersonville	1907	1908		Gilbert M. Wilhelmus, Evansville	1973 1975
*George D. Kahlo, French Lick	1908	1909		Vincent J. Santare, Munster	1974 1976
*Thomas C. Kennedy, Shelbyville	1909	1910			

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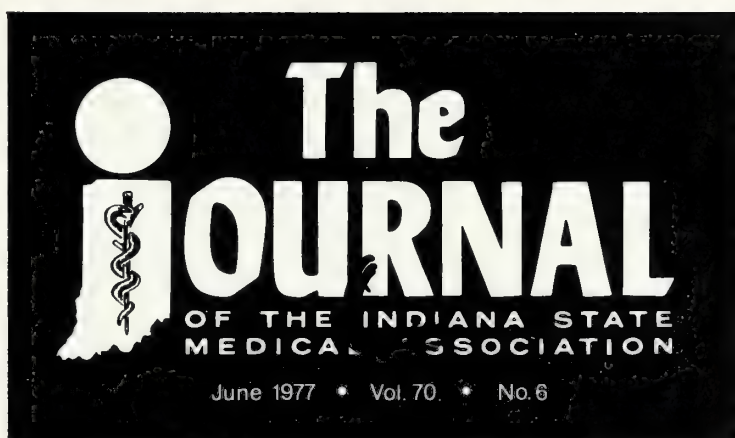
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Following is an alphabetical list of members as of **March 31, 1977.**

The primary specialty appears after the physician's name and the number of the county where the physician is a member appears next. See facing page for explanation of county code numbers.

A list of members by counties begins on page 131/529.

For explanation of Specialty Codes see page 130/528.

If any errors are found, please report them to the Membership Department, ISMA, 3935 N. Meridian St., Indianapolis 46208. The cooperation of members is urgently requested.

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BELEDA, LAMBERTO, VILLAS, RR 2 BOX 373 SHELBYVILLE 46176	IM	206	ADAMS, WM, B, 4608 W JACKSON ST MUNCIE 47304	AN 062
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ACHER, ROBT, PAUL, 221 E WASHINGTON ST GREENSBURG 47240	GP	054	ADE, MARY, EDITH KELLER, 314 NORTH 6TH ST LAFAYETTE 47901	GP 266
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ACTON, CHAS, MICHAEL, 221 SOUTH 66TH ST TERRE HAUTE 47807	D	298	ADLER, FRED, 800 MAC ARTHUR BLVD NO 2 MUNSTER 46321	IM 174
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BAKER, JOHN, C, 1 WEST 26TH ST BOX 368 INDIANAPOLIS 46206	OS	134	BALUYOT, GREGORIO, R, 232 NORTH BROADWAY GREENSBURG 47240	OBG	054
BAKER, JOHN, R, 2321 CARMEL DR WEST LAFAYETTE 47906	AN	286	BALUYUT, AMANDO, L, 210 WEST BOULEVARD PERU 46970	U	194
BAKER, LESLIE, MAYER, 501 4TH ST AURORA 47001	GP	050	BANGUIS, ELISEO, TAMOLA, 103 W WASHINGTON ST SHELBYVILLE 46176	GS	266
BAKER, RAYMOND, C, 3201 OAK HILL ROAD EVANSVILLE 47711	PD	296	BANKOFF, MILTON, LEWIS, 1225 E COOLSPRING MICHIGAN CITY 46360	GP	178
BAKER, SAMMIE, BRUCE, 460 MARTINS LANE EVANSVILLE 47715	R	296	BANNON, WM, G, 400 8TH AVE TERRE HAUTE 47804	IM	298
BAKER, WARREN, 416 E COOLSPRING AVE MICHIGAN CITY 46360	OPH	178	BARBEE, JOHN, YOUNG, 210 PROFESSIONAL ARTS BLDG 1919 STATE STREET NEW ALBANY 47150	OPH	078
BALAGUER, CARMEN, V S, 20 KENWOOD HAMMOND 46324	AN	174	BARCH, JOHN, W, 1301 S HARRISON ST FORT WAYNE 46802	QM	082
BALCH, JAMES, FERGUSON, 8402 HARCOURT RD INDIANAPOLIS 46260	U	134	BARD, FRANK, BRUCE, 305 E HOWARD ST CROTHERSVILLE 47229	GP	138
BALINAO, REUBEN, CASTILLO, PO BOX 197 MICHIGAN CITY 46360	AN	178	BARNARD, ROGER, LESLIE, 408 SOUTH ALVORD EVANSVILLE 47714	FP	296
BALL, CLAY, ADRA, WEST MINSTER VILLAGE MUNCIE MUNCIE 47302	GP	062	BARNES, GILBERT, HARVEY, 513 SOUTH SHERMAN DR INDIANAPOLIS 46203	FP	134
BALL, J, ROBT, 3 RIVERS EAST - STE 108 FORT WAYNE 46802	GS	082	BARNES, HELEN, BEALL, RR 4 GREENWOOD 46142	PD	158
BALL, JOS, EMORY, 6612 E 9TH ST INDIANAPOLIS 46219	GP	134	BARNES, JAMES, V, ELKHART CLINIC ELKHART 46514	IM	070
BALL, MARGARET, J HITZEMAN, 13434 ABOITE CTR RD FORT WAYNE 46804	HEM	082	BARNHART, WILLARD, T, 611 HARRIET ST STE 504 EVANSVILLE 47710	U	296
BALL, W, PHILIP, 2600 W JACKSON ST MUNCIE 47303	IM	062	BARRETT, JAMES, WM, 300 NE 14TH WASHINGTON 47501	TS	046
BALLANTINE, THOS, VAN NESS, 1100 W MICHIGAN INDIANAPOLIS 46202	GS	134	BARRETT, THOS, L, 307 S 5TH ST VINCENNES 47591	PD	162
BALTER, EUGENE, LEE, 1600 W 6TH AVE GARY 46402	R	174	BARRON, ELMER, ABRAHAM, 3535 MICHIGAN AVE EAST CHICAGO 46312	GP	174

BARROS, PAUL, R, 250 S WASHINGTON ST HOBART 46342	OPH	230	BATTERSBY, JAMES, S, 6001 SUNSET LANE INDIANAPOLIS 46208	TS	134
BARTELL, GARY, DENNIS, 2209 JOHN R WOODEN DR MARTINSVILLE 46151	P	202	BATTLE, FREDERICK, GERALD, 3714 FRANKLIN MICHIGAN CITY 46360	GP	178
BARTHELEMY, DOUGE, 2318 W 5TH AVE GARY 46404	HEM	174	BAUER, THOS, BRYANT, 13825 N 107TH DR SUN CITY AZ 85351	PS	134
BARTLEY, MAX, DONALD, 50 E 91ST ST NO 210 INDIANAPOLIS 46240	OPH	134	BAUGHN, WM, LUTHER, 1517 WINDING WAY ANDERSON 46011	OM	186
BARTON, REGINALD, RAYMOND, 6101 MILLER AVE GARY 46403	GP	174	BAUM, JOHN, RUSSELL, 305 7TH ST WINONA LAKE 46590	GP	166
BARTON, ROBT, FRANCIS, 416 E MAUMEE ST ANGOLA 46703	GP	278	BAUMAN, RICHARD, LEE, 700 BROADWAY FORT WAYNE 46802	R	082
BARTON, WILLOUGHBY, M, 316 E MAIN ST CENTERVILLE 47330	FP	314	BAUMEISTER, HERBERT, E, 3266 N MERIDIAN ST INDIANAPOLIS 46208	AN	134
BARTSCH, HARVEY, LEONARD, 61397 MIAMI RD SOUTH BEND 46614	U	258	BAUTISTA, AMANCIO, G, R R 4 565 RIDGEMCNT DR NEWBURGH 47630	AN	296
BASH, STEPHEN, ESTAL, 2828 FAIRFIELD FORT WAYNE 46807	PD	082	BAUTISTA, WARLITO, AVILES, 914 SPRINGDALE JEFFERSONVILLE 47130	IM	034
BASH, WALLACE, EUGENE, 2828 FAIRFIELD FORT WAYNE 46807	PD	082	BAWAB, M, SAMIR, 919 E JEFFERSON ST SOUTH BEND 46622	R	258
BASKETT, RUSSELL, J, 408 S MAIN ST JONESBORO 46938	GP	098	BAXTER, HARRY, R, 209 SOUTH WALNUT ST SEYMOUR 47274	GP	136
BASSETT, MARGARET, ANN, THORNTOWN 46071	FP	022	BAXTER, SAML, MAURICE, 1105 CENTRALIA CT JEFFERSONVILLE 47130	OTO	078
BASTNAGEL, WM, FRANCIS, 8305 CLARIDGE ROAD INDIANAPOLIS 46260	IM	134	BAYAZIT, LUTFI, Y, 229 MEDICAL CENTER BLDG FORT WAYNE 46805	GP	082
BATAKAN, GEO, ACOSTA, 2208 FLAIRMONT TR L B MICHIGAN CITY 46360	P	178	BEACH, NORMAN, F, 919 E JEFFERSON BLVD SOUTH BEND 46622	R	258
BATCHELDER, JOHN, ERNEST, 1500 ALBANY ST NO 101 BEECH GROVE 46107	CD	134	BEACH, ROBT, RUSSEL, 5810 PLEASANT RUN PKWY INDIANAPOLIS 46219	OS	134
BATE, MOSTAFA, HASHEM, 8402 HARCOURT RD INDIANAPOLIS 46260	GS	134	BEAMS, RALPH, H CURIE, 731 MED CENTER FORT WAYNE 46802	OPH	082
BATES, LAURENCE, HOWARD, 3524 N MERIDIAN INDIANAPOLIS 46208	IM	134	BEAMS, RONALD, NED, 12023 EDEN GLENN DRIVE CARMEL 46032	OPH	134
BATNITZKY, SOLOMON, 8950 SOURWOOD COURT INDIANAPOLIS 46260	R	134	.		

BEAN, JOS, STRATTON, TWO CHASE PARK LOGANSPOET 46947	R	030	BECKMAN, ARTHUR, JOS, 12110 GRANT ST CROWN POINT 46307	GP	174
BEAN, WM, JOS, 1251 KEM RD MARION 46952	D	098	BECONOVICH, ROBT, 7905 CALUMET AVE MUNSTER 46321	GP	174
BEARDSLEY, FRANK, A, 1201 OAK ST FRANKFORT 46041	GP	042	BEDWELL, MARION, HADDON, 16 N COURT ST SULLIVAN 47882	GP	282
BEATTY, BRUCE, EUGENE, 8962 CRAWFORDSVILLE RD INDIANAPOLIS 46234		134	BEELER, BARBARA, ANN, 8402 HARCOURT ROAD INDIANAPOLIS 46260	ID	134
BEAVEN, JOHN, B, 721 W 13TH ST-STE 102-103 JASPER 47546	ABS	066	BEELER, FRANKLIN, K, 1931 BROWN ST ANDERSON 46014	FP	186
BEAVER, ERNEST, RAYMOND, 111 THOMPSON ST RENSSELAER 47978	FP	142	BEELER, JOHN, WATSON, 7974 N ILLINOIS ST INDIANAPOLIS 46260	R	134
BEAVER, HOWARD, WILSON, 3101 S MERIDIAN ST INDIANAPOLIS 46217	GP	134	BEERING, STEVEN, CLAUS, IU MEDICAL CTR INDIANAPOLIS 46202	IM	134
BECHTOL, LAVON, DEE, LILLY CLINIC GEN HOSP INDIANAPOLIS 46202	PA	134	BEESLEY, RICHARD, ROY, 2600 GREENBUSH ST LAFAYETTE 47904	PD	286
BECHTOLD, DAVID, LEE, 919 EAST JEFFERSON BLVD SOUTH BEND 46622	GS	258	BEESON, WILBUR, P, 120 W MC KENZIE GREENFIELD 46140	FP	110
BECHTOLD, SAML, E, 17545 JUDAY LAKE DR SOUTH BEND 46635	OBG	258	BEESON, WILLIAM, H, 13 FARR HILLS DR WESTFIELD 46074		134
BECK, DAVID, C, 402 NORTHWESTERN SUITE 106 WEST LAFAYETTE 47906	D	286	BEGGS, LOWELL, FREDERICK, 832 WASHINGTON ST COLUMBUS 47201	GS	014
BECK, EVART, MALCOLM, 915 E 38TH ST INDIANAPOLIS 46205	IM	134	BEGLEY, JOS, W, 314 S E RIVERSIDE DR EVANSVILLE 47713	OTO	296
BECK, JAMES, PHILLIP, 1312 BEDFORD ROAD WASHINGTON 47501	IM	046	BEHN, WALTER, MARTIN, 1900 68TH ST N 302 ST PETERSBURG FL 33710	GP	174
BECK, ROBT, E, 611 HARRIETT STE 103 EVANSVILLE 47710	R	296	BEHREND, FRANK, LUDWIG, 1101 GLENDALE BLVD VALPARAISO 46383	OBG	230
BECKER, HARRY, GREGORY, 6060 N COLLEGE AVE INDIANAPOLIS 46220	GS	134	BEIERLEIN, KARL, M, 2716 BUTLER ROAD FORT WAYNE 46808	OBG	082
BECKER, JERRY, DONNELL, 515 READ ST EVANSVILLE 47710	IM	296	BEIGHTS, RAYMOND, SAML, 2200 RANDALIA DR FORT WAYNE 46805	GP	082
BECKER, LOWELL, ERVIN, 119 WEST RUDISELL BLVD FORT WAYNE 46807	CHP	082	BEISEL, LARRY, HOMAN, 421 CHESTNUT ST EVANSVILLE 47713	PD	296
BECKER, SAML, WM, 2075 INDIANAPOLIS BLVD WHITING 46394	D	174	BEISER, GEO, DAVID, 4321 FIR ST EAST CHICAGO 46312	CD	174

BELANGER, ROBT, ALLEN, 5029 BLUM DR FORT WAYNE 46815	082	BENNETT, JENE, R, 531 N MAIN ST SOUTH BEND 46601	PTH	258
BELCHER, ALAN, DEVON, MARION GEN HOSP MARION 46952	R	096 BENNETT, RONALD, G, 3200 SYCAMORE CT SUITE 1A COLUMBUS 47201	ORS	014
BELSHAW, GEO, HENRY, 1640 N RITTER AVE INDIANAPOLIS 46218	OBG	134 BENNETT, WM, SHERMAN, 1815 N CAPITAL AVE INDIANAPOLIS 46202	AN	134
BELT, JAMES, H, 8801 N MERIDIAN INDIANAPOLIS 46260	PD	134 BENSON, JAMES, EDMUND, BOX 2507 ELKHART 46514	P	070
BEMAN, JOHN, W, 421 CHESTNUT ST EVANSVILLE 47713	OTO	296 BENSON, JESSE, THOS, 650 N GIRLS SCH RD INDIANAPOLIS 46224	OBG	134
BENCHIK, FRANK, AUGUST, 4712 MAGOUN AVE EAST CHICAGO 46312	FP	174 BENTZ, JOHN, MARVIN, 418 WILLOWBROOK BLUFFTON 46714	OBG	318
BENDER, BRUCE, HAROLD, 4949 CARSON AVE INDIANAPOLIS 46227	IM	134 BENZ, JAMES, ALBERT, 1001 W 10TH ST INDIANAPOLIS 46202	FOP	134
BENDER, MARTIN, JOHN, 3700 BELLMEADE EVANSVILLE 47715	U	296 BENZ, JESSE, C, 112 16TH AVE N ST PETERSBURG FL 33704	GP	114
BENDLER, CARL, HENRY, 198 COUNTRY CLUB RD BOX 756 LAKE MARY FL 32746	GP	174 BERGAL, MILTON, B, 2318 W 5TH AVE GARY 46404	GP	174
BENEDICT, HAROLD, GAYMAN, 1916 JACKSON ST ANDERSON 46014	GP	186 BERGAN, JOS, ANTHONY, 217 W HOMER ST MICHIGAN CITY 46360	GS	178
BENEDICT, PAUL, FRANCIS, 5626 E 16TH INDIANAPOLIS 46218	GS	134 BERGHOFF, JAMES, RAYMOND, 3702 RUPP DR FORT WAYNE 46805	OM	082
BENJAMIN, SAMSON, ADAM, 7 TWIN OAKS RR 8 CRAWFORDSVILLE 47933	OBG	198 BERGWALL, WARREN, L, 2923 W JACKSON MUNCIE 47304	FP	062
BENKEN, LAWRENCE, D, 1111 W JACKSON ST MUNCIE 47305	OBG	062 BERKE, ROBT, D, 1118 LINCOLN WAY E SOUTH BEND 46618	A	258
BENNETT, ABNER, P, WELBORN BAPTIST HOSP EVANSVILLE 47713	PTH	296 BERKER, BEDII, S, P O BOX 2464 MUNCIE 47302	AN	062
BENNETT, BENJ, DOUGLAS, 402 SOUTH BERKLEY RD KOKOMO 46901	GP	126 BERKSHIRE, SHAFFER, B, 2400 EAST 17TH STREET COLUMBUS 47201	R	014
BENNETT, DICK, L, 1624 24TH ST BEDFORD 47421	AN	182 BERKSON, MYRON, E, 1101 E COOLSPRING AVE MICHIGAN CITY 46360	P	178
BENNETT, IVAN, FRANK, 8452 GREEN BRAES DR N INDIANAPOLIS 46234	P	134 BERMAN, EDWARD, J, 3426 N MERIDIAN ST INDIANAPOLIS 46207	PDS	134
BENNETT, JAMES, E, INDIANA UNIV MED CTR INDIANAPOLIS 46202	PS	134 BERMAN, JACOB, KOHN, 3939 COOPER LANE INDIANAPOLIS 46208	GS	134

BERNARD, MARVIN, K, 5500 EAST 81ST AVE MERRILLVILLE 46410	NS	174	BIGLER, FREDERICK, W, 124 PARMLEY GOSHEN 46526	AN	070
BERNER, HERBERT, WM, 2501 W JACKSON MUNCIE 47303	OBG	062	BILL, ROBT, O, 3231 N MERIDIAN ST INDIANAPOLIS 46208	PYA	134
BERRY, GEORGE, F, 3700 BELLEMEADE AVE EVANSVILLE 47715	FP	296	BILLINGS, ELMER, RAY, BOX 2507 ELKHART 46514	IM	070
BERRY, MARGARET, 8402 HARCOURT RD INDIANAPOLIS 46260	IM	134	BILLINGSLEY, JOHN, SMITH, 2828 FAIRFIELD AVE FORT WAYNE 46807	R	082
BERUBEN, MIGUEL, F, P O BOX 3159 EAST CHICAGO 46312	IM	174	BILLS, ROBT, J, 504 BROADWAY GARY 46402	GS	174
BEST, ROBT, C, 2075 INDIANAPOLIS BLVD WHITING 46394	GP	174	BILLS, ROBT, NOEL, 504 BROADWAY GARY 46402	GS	174
BEUERMAN, VIRGIL, ADOLPH, 2600 GREENBUSH ST LAFAYETTE 47905	OPH	286	BILODEAU, RICHARD, GERARD, RR NO 6 BOX 400 NOBLESVILLE 46060	DR	106
BEUTLER, THEODORE, V, 527 W BERRY ST FORT WAYNE 46802	U	082	BIRD, JOHN, J, 710 JMS BLDG SOUTH BEND 46601	OPH	258
BEVERS, MARK, MITCHELL, 209 SOUTH WALNUT ST SEYMOUR 47274	FP	138	BISHOP, MICHAEL, DARYL, BLOOMINGTON HOSP-EMERG DEPT BLOOMINGTON 47401	EM	214
BHAGWANDIN, HARRY, OMROA, 4761 SOUTHEASTERN AVE INDIANAPOLIS 46203	GP	134	BISSONNETTE, ROGER, P, 421 CHESTNUT ST EVANSVILLE 47713	IM	296
BHANGOO, SUKMINDER, SINGH, 1350 CHESTER BLVD RICHMOND 47374	AN	314	BIXLER, DONALD, PAUL, P O BOX 1835 ANDERSON 46014	OPH	186
BIBLER, LESTER, DAVID, 4360 N PENN INDIANAPOLIS 46205	FP	134	BIXLER, JAMES, AMOS, MED-DENTAL BLDG-3030 LAKE AVE FORT WAYNE 46805	OPH	082
BICALHO, JOSE, FERNAL, 6111 HARRISON ST MERRILLVILLE 46410	ORS	174	BIZAL, JOHN, ADOLPH, 314 S E RIVERSIDE EVANSVILLE 47712	OTO	296
BICKERS, EVERETT, EARL, R R 3 BOX 572 FLOYDS KNOBS 47119	GP	078	BIZER, MIER, A, 1206 SPRING ST JEFFERSONVILLE 47130	GP	034
BIDNEY, EVELYN, BRESLIN, 5946 NORTH NEW JERSEY ST INDIANAPOLIS 46220	GP	214	BLACK, BOYD, K, GODD SAMARITAN HOSP VINCENNES 47591	PTH	162
BIEGEL, ANGENIETA, ANNE, 2842 STILLMAN AVE INDIANAPOLIS 46268	IM	134	BLACK, JOS, MORTON, 671 BRAWICK RD SEYMOUR 47274	GP	138
BIERMAN, GILBERT, HENRY, 717 BROADWAY FORT WAYNE 46802	ORS	082	BLACK, KENNETH, A, 2674P PORTAGE MALL PORTAGE 46368	FP	230
BIGLAN, ALBERT, W, 4932 OAKBROOK DRIVE INDIANAPOLIS 46256	OPH	134	BLACK, M, JAMES, BOX 36 BROWNSBURG 46112	GP	118

BLACK, THOS, HGUSTON, 600 NORTH ARLINGTON GREENCASTLE 46135	FP	242	BLOOM, GEO, ROBT, 236 SIMPSON ELKHART 46514	FP	076
BLACKBURN, ROBT, ALFRED, 3530 SOUTH KEYSTONE NO 310 INDIANAPOLIS 46227	OTO	134	BLOOMER, RICHARD, SAML, 115 N MARKET ST ROCKVILLE 47872	GP	216
BLACKFORD, FLORENCE, SMITH, 5909 E 10TH ST INDIANAPOLIS 46219	R	134	BLOSS, BRYANT, ALLEN, 801 ST MARYS DR SUITE 410 EVANSVILLE 47715	ORS	296
BLACKFORD, RALPH, ELLIS, 5909 E 10TH ST INDIANAPOLIS 46219	GP	134	BLOSSOM, PAUL, WRIGHT, 825 SOUTH A ST RICHMOND 47374	GP	314
BLACKWELL, DONALD, S, 1815 N CAPITOL AVE INDIANAPOLIS 46202	ORS	134	BLOXDORF, JOHN, WM, BOX 1468 TERRE HAUTE 47808	PTH	298
BLAIR, RICHARD, GEO, 3 PARKMOOR DRIVE HUNTINGTON 46750	GP	130	BLUE, EARL, ROBT, HOWARD COMM HOSP KOKOMO 46901	R	126
BLAISDELL, WM, FREDERICK, 1124 MEDICAL PL SEYMOUR 47274	GP	138	BLUM, LEON, LEIB, P O BOX 1468 TERRE HAUTE 47808	PTH	298
BLAKE, ALBERT, L, 5508 EAST 16TH ST INDIANAPOLIS 46218	IM	134	BLYTHE, JERRY, EDWARD, 924-A PARK CENTRAL DR S INDIANAPOLIS 46260	GP	134
BLANCO, RAMON, M, 2167 GETTLER ST DYER 46311	NS	174	BOAZ, WM, DALE, 1025 MANCHESTER AVE WABASH 46992	GP	302
BLANDO, ULDARICO, BRINGAS, 6101 BIRCH ST GARY 46403	R	236	BOBB, KENNETH, E, 410 S CHESTNUT ST SEYMOUR 47274	FP	138
BLASSARAS, CRIST, A, 2005 BROADWAY ANDERSON 46013	GP	186	BOBERG, ARTHUR, RICHARD, 420 W WASHINGTON ST MUNCIE 47305	IM	062
BLATT, ADOLPH, EBNER, 3266 N MERIDIAN ST APT 306 INDIANAPOLIS 46208	IM	134	BODNAR, LESLIE, M, P O BOX P ROOM 102 NOTRE DAME 46556	ORS	258
BLESSINGER, LOUIS, HENRY, 101 W CHESTNUT ST CORYDON 47112	GP	114	BOEN, BRADLEY, NELSON, 620 8TH AVE TERRE HAUTE 47804	P	298
BLEZA, MAXIMO, TULABOT, 7905 CALUMET AVE MUNSTER 46321	OM	174	BOESTER, JEFFREY, ALLYN, 6130 REDCOACH COURT INDIANAPOLIS 46250	OBG	134
BLICHERT, PETER, A, THREE RIVERS E STE 104 FORT WAYNE 46802	OBG	082	BOGGS, EUGENE, FULTON, 8 E TROY AVE INDIANAPOLIS 46225	IM	134
BLIX, FRED, MAYOR, 8402 HARCOURT ROAD SUITE 513 INDIANAPOLIS 46260	FP	134	BOHA, MARIA, AGNES SZITTYA, 1919 STATE STREET SUITE 104 NEW ALBANY 47150	GP	078
BLOEMKER, EDWARD, F, 6145 BRYAN DR INDIANAPOLIS 46227	GP	134	BOHA, RUDOLF, LASZLO, 1919 STATE ST NEW ALBANY 47150	GP	078
BLOOM, A, WARD, 610 RIVER DR MARION 46952	PH	098	BOHLING, JEFFREY, LUKE, 7101 MONROE AVE EVANSVILLE 47715	OBG	296

BOJRAB, LOUIS, DEAN, 3663 WALDEN PL CARMEL 46032	AN	134	BOOTH, FRANKLIN, M, 3610 NORTHSIDE BLVD SOUTH BEND 46615	PS	258
BOLIN, ROBT, CORNWALL, 2600 GREENBUSH LAFAYETTE 47902	IM	286	BOOZE, JAMES, H, 711 W 2ND ST BLOOMINGTON 47401	ORS	214
BOLING, FREDERICK, FRANCIS, 3049 S HOLT ROAD INDIANAPOLIS 46241	GP	134	BOPP, HENRY, WM, 221 S 6TH ST TERRE HAUTE 47807	GS	298
BOLING, GROVER, C, 1440 EAST 46TH ST INDIANAPOLIS 46205	GP	134	BORDER, JOHN, FRANKLIN, 3729 W JACKSON MUNCIE 47304	CD	062
BOLING, RICHARD, CLAYTON, 1332 W INDIANA AVE ELKHART 46514	OPH	070	BOREN, PAUL, RANDOLPH, POSEYVILLE 47633		234
BOLINGER, GARRY, LEE, 301 E 38TH ST INDIANAPOLIS 46205	CLP	134	BORLAND, RAYMOND, MILTON, R D 3 BOX 51 BLOOMINGTON 47401	PH	214
BOLLHEIMER, DON, ALLEN, 623 MED CTR BLDG FORT WAYNE 46802	OPH	082	BORNSTEIN, HERSCHEL, 3233 BROADWAY GARY 46409	GP	174
BOMALASKI, MARTIN, DONALD, 1005 KUEBLER PL JASPER 47546	DR	066	BOSCH, RALPH, OTTO, 930 SOUTH DRIVE SEYMOUR 47274	IM	138
BOMBA, BRAD, JOS, 515 WOODCREST DR BLOOMINGTON 47401	GP	214	BOSLER, HOWARD, AARON, 2000 SOUTH 15TH ST APT D 3-2 GOSHEN 46526	OS	070
BOMBAR, LESLIE, EUGENE, 7905 CALUMET AVE MUNSTER 46321	GP	174	BOSLEY, ROGER, EUGENE, 2400 FERRY ST LAFAYETTE 47904	OBG	286
BOND, LARRY, GENE, 2600 GREENBUSH ST LAFAYETTE 47904	D	286	BOSSARD, JOHN, W, LAKE MAYCREST BLDG STE 9 FORT WAYNE 46805	NS	082
BOND, VIRGINIA, KING, 4525 W 59TH ST INDIANAPOLIS 46254	AN	134	BOTKIN, CHAS, THOS, 400 WHITE RIVER BLVD MUNCIE 47303	GP	062
BONSETT, CHAS, A, 6133 E 54TH PL INDIANAPOLIS 46226	N	134	BOTKIN, CLYDE, GARRETT, 520 WEST MAIN ST MUNCIE 47305	GP	062
BOONE, CLARENCE, WAYNE, 2200 GRANT ST GARY 46404	OBG	174	BOTKIN, JAMES, EDWARD, 706 RIVER DR MARION 46952	FP	098
BOONE, CRAIG, DANL, 5820 STONERIDGE DR INDIANAPOLIS 46226	EM	314	BOURKE, WM, W, 1211 EUCLID AVE MARION 46952	P	098
BOONE, ROBT, D, 421 CHESTNUT ST EVANSVILLE 47713	TS	296	BOURLAND, BARBARA, JOHNSON, 807 CUMBERLAND WEST LAFAYETTE 47906	PD	286
BOONJARERN, SAMPANTA, 7895 BROADWAY MERRILLVILLE 46410	U	174	BOWDOIN, GEO, EDWARD, 2580 ESTERO BLVD NO 21 FORT MYERS BEACH FL 33931	GP	070
BOOTH, BOYNTON, HOOKER, 8801 N MERIDIAN ST SUITE 209 INDIANAPOLIS 46260	D	134	BOWEN, GERALD, THOS, 705 TANNER AVE LAWRENCEBURG 47025	FP	050

BOWEN, OTIS, RAY, 4750 NORTH MERIDIAN ST INDIANAPOLIS 46208	GP	190	BRADLEY, RICHARD, VINCENT, R R NO 2 BOX 281 GREENTOWN 46936	GP	126
BOWERS, CHAS, RICHARD, 2009 BROWN ST ANDERSON 46014	GS	186	BRADY, KINGDON, 612 TERRY LANE LAFAYETTE 47906	PTH	286
BOWERS, COPELAND, C, 18145 FOREST VIEW RD MONUMENT CO 80132	GP	126	BRADY, THOMAS, A, 1815 N CAPITOL INDIANAPOLIS 46202	GRS	134
BOWERS, JESSE, W, 1830 FOREST PARK BLVD FORT WAYNE 46805	GS	082	BRAKEL, FRANK, J, 421 CHESTNUT ST EVANSVILLE 47713	IM	296
BOWERSOX, LE, ROY WM, 19519 COUNTY RD N 146 NEW PARIS 46553	PTH	070	BRANAM, GEO, EVERETT, 1138 WARWICK RD MUNCIE 47304	PTH	062
BOWMAN, JOHN, ALDEN, 5602 FOUR MILE HILL DR KOKOMO 46901	P	126	BRANCO, ARTHUR, MATTHEW, 7905 CALUMET AVE MUNSTER 46321	GS	174
BOWMAN, LEON, WILSON, 104 PROFESSIONAL ARTS BLDG NEW ALBANY 47150	GP	078	BRAND, ANNA, S, 656 WENTWORTH AVE CALUMET CITY IL 60409	GP	174
BOWSER, PHILIP, GORTNER, 107 S 5TH ST GOSHEN 46526	GP	070	BRANDES, DAVID, CHAS, 123 RIVER DR MARION 46952	U	098
BOYCE, PAUL, ACHILLES, 5235 N MERIDIAN ST INDIANAPOLIS 46208	DIA	134	BRANDMAN, HARRY, 251 WEST SOUTH ST JO 13 GALESBURG IL 61401	P	174
BOYD, CARL, RITTER, TWO CHASE PARK LOGANSPOET 46947	R	030	BRANDT, WM, E, 618 W BERRY ST FORT WAYNE 46802	GS	082
BOYD, HARVEY, CLARK, 221 S 6TH ST TERRE HAUTE 47807	GYN	298	BRANTLY, JAMES, MONROE, 11175 SOUTHEASTERN AVE INDIANAPOLIS 46259	IM	134
BOYER, DON, W, 1604 N LEBANON ST LEBANON 46052	GS	022	BRASHEAR, RICHARD, 7070 WASHINGTON BLVD INDIANAPOLIS 46220	PUD	134
BOYER, FLOYD, ALFRED, 136 S WITTFIELD INDIANAPOLIS 46229	GP	134	BRASOVAN, SRBISLAV, N, 6111 HARRISON ST MERRILLVILLE 46410	OBG	174
BOYER, GRACE, BESHGETOOR, 607 LOCUST ST MARION 46952	OBG	098	BRAUER, ABRAHAM, A, 1010 REYOME DR GRIFFITH 46319	P	174
BOYS, FAY, FRANK, 250-7TH AVE SOUTH NAPLES FL 33940	GP	174	BRAUN, STEPHEN, EARL, 2301 W MICHIGAN ST EVANSVILLE 47712	OS	296
BOZE, ROBT, L, 265 W WATER ST BERNE 46711	GP	010	BRAUNLIN, ROBT, JUSTICE, 5110 N CLINTON FORT WAYNE 46825	OTO	082
BRACEY, ALTAMONT, HART, 2600 GREENBUSH ST LAFAYETTE 47904	PDS	286	BRAYTON, LEE, 3930 N ILLINOIS ST INDIANAPOLIS 46208	GP	134
BRADLEY, LOUIS, FRANCIS, 303 S MAIN BLUFFTON 46714	IM	318	BRECHTL, HARVEY, J, 119 S EDDY ST SOUTH BEND 46617	GP	258

BREITWEISER, THOS, DAVID, 122 FAIRMONT DR MADISON 47250	R	150	BRITTON, WELBON, DUNLAP, R D 1 MONTEZUMA 47862	GP	216
BREMER, WINDHAM, 1511 WABASH MICHIGAN CITY 46360	R	178	BROCKMAN, WILFRED, J, 439 E CHESTNUT ST CORYDON 47112	GP	114
BRENNAN, BETSY, BECKER, 1930 FISHER PL MUNSTER 46321	D	174	BRODERSEN, JAMES, DENNIS, 7905 CALUMET AVE MUNSTER 46321	OPH	174
BRENNAN, THOS, FRANCIS, ARNETT CLINIC 2600 GREENBUSH LAFAYETTE 47904	OTO	286	BROGAN, THOS, MICHAEL, 1265 W 86TH STREET INDIANAPOLIS 46260	GP	134
BRENNAN, WM, CLARENCE, 2833 LINCOLN ST HIGHLAND 46322	GS	174	BROMLEY, LUMAN, W, 5717 SOUTH ANTHONY BLVD FORT WAYNE 46805	ORS	082
BRENNER, HOWARD, B, 800 MAC ARTHUR BLVD MUNSTER 46321	UBG	174	BRONSON, PAUL, JONES, 58 ALLENDAL TERRE HAUTE 47802	OBG	298
BRENNER, HUGO, ANTONIO, 101 SUZIE LANE ATTICA 47918	GS	086	BRONSON, WILLIAM, W, 202 S 32ND ST RICHMOND 47374	EM	314
BREWER, ROBT, ALLEN, 216 9TH ST LOGANSPORT 46947	OS	030	BROOKS, FRED, REYNOLDS, 1660 CUNNINGHAM DR INDIANAPOLIS 46224	GP	134
BRICKLEY, HARRY, D, 3266 N MERIDIAN 608 INDIANAPOLIS 46208	GS	134	BROOMES, EDWARD, LOUIS, 2402 BROADWAY EAST CHICAGO 46312	GP	174
BRICKLEY, RICHARD, AGAR, 3266 N MERIDIAN STE 608 INDIANAPOLIS 46208	GS	134	BROSHEARS, KENNETH, P, 129 E VINCENNES ST LINTON 47441	GP	102
BRIDGE, BARTON, C, JEFFERSON SQUARE LAFAYETTE 47905	GP	286	BROSIUS, ROBT, HENRY WM, 1603 WELLS ST FORT WAYNE 46808	GP	082
BRIDGES, ALVIN, L, 1302 MADISON AVE ANDERSON 46011	FP	186	BROWN, ARCHIE, EMMETT, 5575 GULF BLVD APT 220 ST PETERSBURG FL 33706	IM	134
BRIDGES, WM, L, 2200 LAKE AVE SUITE 150 FORT WAYNE 46805	R	082	BROWN, ARLIN, EDWARD, 619 WEST 1ST ST BLOOMINGTON 47401	P	214
BRILL, JOS, B, 207 SPARKS AVE JEFFERSONVILLE 47130	P	034	BROWN, DAVID, EDWARD, 1944 N CAPITOL ST INDIANAPOLIS 46202	OTO	134
BRILLHART, JAMES, RICHARD, 5506 E 16TH ST INDIANAPOLIS 46218	OBG	134	BROWN, DAVID, LEE, 1604 NORTH CAPITOL INDIANAPOLIS 46202	DR	134
BRINCKO, JOHN, 6111 HARRISON MERRILLVILLE 46410	U	174	BROWN, DE, WITT WILCOX, 1815 NORTH CAPITOL AVE NO 202 INDIANAPOLIS 46202	P	134
BRISSENDEN, REYNOLDS, 320 N MERIDIAN ST ROOM 812 INDIANAPOLIS 46204	OM	134	BROWN, EARL, ROBT, 1500 N RITTER AVE INDIANAPOLIS 46219	DR	134
BRITT, ROBT, LEE, 421 CHESTNUT ST EVANSVILLE 47713	PD	296	BROWN, FRANCES, TURPIN, 2126 N TALBOTT AVE INDIANAPOLIS 46202	GP	134

BROWN,GARLAND,RICHARD, 5522 W HAMILTON FORT WAYNE 46804	R	082	BROWNING,CHAS,A, 1400 CHESTER BLVD RICHMOND 47374	AN	314
BROWN,GEO,EDWIN, P O BOX 328 GREENWOOD 46142	GP	158	BROWNING,WM,MADISON, R R 1 BOX 221 E NINEVEH 46164	OS	134
BROWN,GORDON,T, 3266 N MERIDIAN STE 609 INDIANAPOLIS 46208	P	134	BROWNLEY,EMMA,J, 2840 N HIGH SCHOOL RD SPEEDWAY 46224	PD	134
BROWN,JAMES,RICHARD, 1005 N CAMPBELL ST VALPARAISO 46383	U	230	BRUBAKER,HAROLD,S, 1515 DEL WEB BLVD SUN CITY CENTER FL 33570	AN	130
BROWN,JOHN,MICHAEL, 2400 FERRY ST LAFAYETTE 47904	OBG	286	BRUBAKER,THOS,ALBERT, BALL MEM HOSP DEPT MED MUNCIE 47303	IM	174
BROWN,JOHN,STANLEY, R R GREENBRIER HILLS SULLIVAN 47882	GP	282	BRUBECK,ROBT,EUGENE, 1400 E COLUMBUS ST MARTINSVILLE 46151	GP	202
BROWN,KENNETH,HOMER, 1654 HEDDEN PARK NEW ALBANY 47150	GP	078	BRUCKER,PERRY,ALBERT, 102 THREE RIVERS E FORT WAYNE 46802	PS	082
BROWN,LELAND,G, 412 WHITE RIVER BLVD MUNCIE 47303	OKS	062	BRUCKMAN,JOS,ALAN, 302 PROFESSIONAL ARTS BLDG 1919 STATE STREET NEW ALBANY 47150	U	078
BROWN,LEO,RALPH, 7863 BROADWAY STE 205 MERRILLVILLE 46410	GP	174	BRUECKMANN,F,ROBERT, 1815 N CAPITAL INDIANAPOLIS 46202	ORS	134
BROWN,MARCEL,SINCLAIR, ROUTE 1 HAINES CITY FL 33844	GP	214	BRUEGGE,THEODORE,JOS, 2919 BURTON DR BOX 2044 KOKOMO 46901	OM	126
BROWN,RAYMOND,LEE, 401 S E 6TH ST EVANSVILLE 47713	AN	296	BRUEGGEMANN,WALTER,GEO, 2418 BEAM RD COLUMBUS 47201	OPH	014
BROWN,RICHARD,J, 400 S BERKLEY RD STE C KOKOMO 46901	U	126	BRUETSCH,WALTER,L, 2663 TALLANT RD SANTA BARBARA CA 93105	PTH	134
BROWN,ROBT,MC DOWELL, 521 MARION NATL BK MARION 46952	GP	098	BRUNDICK,EDWARD,L, 611 HARRIET ST EVANSVILLE 47710	ORS	296
BROWN,RONALD,ROBT, 1200 CHESTER BLVD RICHMOND 47374	IM	314	BRYAN,FRANKLIN,ABRAM, 2101 COLISEUM EAST FORT WAYNE 46805	OS	082
BROWN,STEWART,DALE, 349 W 1ST ST ALBANY 47320	FP	062	BRYAN,STANTON,L, 607 HULMAN BLDG EVANSVILLE 47708	IM	296
BROWN,THOS,CISEL, DEPARTMENT OF RADIOLOGY GOOD SAMARITAN HOSPITAL VINCENNES 47591	R	066	BRYANT,EDWARD,GAREY, 2220 BROADWAY EAST CHICAGO 46312	GP	174
BROWN,THOS,MARTIN, 212 N PAULINE AVE MUNCIE 47303	IM	062	BUCHHOLZ,JAMES,G, 2609 FAIRFIELD AVE FORT WAYNE 46807	ORS	082
BROWN,WENDELL,EDGAR, 5005 E 72ND ST INDIANAPOLIS 46250	PD	134	BUCHMAN,MARSHALL,HARDING, 1824 STATE ST NEW ALBANY 47150	GP	078

BUCK,RICHARD,CRAIG, 51916 US 31 NORTH SOUTH BEND 46637	FP	258	BUNAG,HOMER,UY, 800 MAC ARTHUR BLVD WEST WING SUITE 31 MUNSTER 46321	OTO	174
BUCK,RODGER,LEWIS, 9 CRANE AVE SPENCER 47460	GP	214	BUNDY,VERNON, 700 SPRING ST NEW ALBANY 47150	GS	078
BUCKEL,LARRY,JOS, 1500 ALBANY ST BEECH GROVE 46107	D	134	BUNKER,LADOSKA,ZEE, 201 N MILL ST NORTH MANCHESTER 46962	GP	302
BUCKINGHAM,RICHARD,E, BOX 415 BLOOMINGTON 47401	GP	214	BUNTIN,PRESLEY,THOS, 725 FOREST BLVD ZIONSVILLE 46077	GS	134
BUCKLES,DAVID,LUDY, ST JOHNS HOSP ANDERSON 46011	CLP	186	BURACK,WALTER,R, YOUNGSTOWN SHEET AND TUBE CO EAST CHICAGO 46312	IM	174
BUCKNER,GEO,DOSTER, 1003 FULTON ST FORT WAYNE 46802	GS	082	BURCHAM,JAMES,BENJ, MADISON STATE HOSP MADISON 47250	GP	150
BUDDRUS,DAVID,J, 1127 MYRTLE STREET ELKHART 46514	PA	070	BURDETTE,HAROLD,F, 6310 GLEN COE INDIANAPOLIS 46200	IM	134
BUECHLER,JAMES,RAYMOND, 1513 N 6 1/2 ST TERRE HAUTE 47804	FP	298	BURGER,THOS,C, 3700 BELLEMEADE AVE EVANSVILLE 47715	GS	296
BUECHLER,WM,F, 1817 SOUTH A ST ELWOOD 46036	GP	186	BURGHARD,ROLLA,DALE, 1500 N RITTER ST INDIANAPOLIS 46219	EM	134
BUECHNER,FREDERICK,W, 261 OLIVER THEATRE A SOUTH BEND 46601	GP	258	BURK,JAMES,MERRYMAN, 115 N 3D ST DECATUR 46733	GP	010
BUEHL,FREDERICK,HELM, 520 SOUTH SEVENTH ST VINCENNES 47591	P	162	BURKET,CECIL,R, 424 W SOUTH ST BREMEN 46506	GP	190
BUEHL,ISABELLE,ANN DAVIS, R R 3 BOX 229 GREENWOOD 46142	PTH	134	BURKHARDT,BOYD,ALONZA, 120 WALNUT ST P O BOX 375 TIPTON 46072	ABS	290
BUEHLER,GEO,MICHAEL, 914 SPRINGDALE DR JEFFERSONVILLE 47130	GP	034	BURKLE,ROBERT,J, 2929 S 1ST ST TERRE HAUTE 47802	OKS	298
BUEHNER,DONALD,CLEMENS, 3700 BELLEMEADE AVE EVANSVILLE 47715	FP	296	BURNETT,ARTHUR,BAKER, 801 MELODY LN NEW CASTLE 47362	OPH	122
BUEHNER,DONALD,F, 3700 BELLEMEADE AVE EVANSVILLE 47715	FP	296	BURNIKEL,RAYMOND,H, 2709 WASHINGTON EVANSVILLE 47714	CRS	296
BUKATA,PEDRO, 110 RIDGE ROAD MUNSTER 46321	OBG	174	BURNS,ANTHONY,JOHN, 2810 ETHEL AVE MUNCIE 47304	AN	062
BULLARD,HARLAN,R, 2600 GREENBUSH ST LAFAYETTE 47904	OPH	286	BURNS,JOHN,T, 2323 SOUTH ST LAFAYETTE 47904	PD	286
BULLINGTON,GEO,EDWIN, 1230 E KING FRANKLIN 46131	DR	158	BURNS,PAUL,EARLAND, 121 E HIGH ST MONTPELIER 47359	GP	062

NAME	PD	134	C	GP	314
URT, MICHAEL, ROBT, 7818 PROVIDENCE CIR INDIANAPOLIS 46250	PD	134	CABIGAS, JOSE, SOVISO, 516 NATIONAL RD W RICHMOND 47374	GP	314
URTON, ROBT, L, 215 BROADWAY GARY 46402	OM	174	CABRERA, JUAN, CABRERA, 1111 SOUTH GREEN RIVER RD EVANSVILLE 47715	CHP	296
URWELL, STANLEY, WOODRUFF, 424 W JACKSON ST MUNCIE 47305	GS	062	CABRERA, PELAYO, BONSON, 1304 W 124TH PL CROWN POINT 46307	PTH	174
USH, CHAS, EDGAR, 1201 OAK ST FRANKFORT 46041	GP	042	CACDAC, FE, JOSON, 2929 S 1ST ST TERRE HAUTE 47807	FP	298
USH, EDWARD, ROBT, 2101 JACKSON SUITE 111 ANDERSON 46014	GP	186	CACDAC, MANUEL, ARCE, 2929 SOUTH FIRST ST TERRE HAUTE 47802	NS	298
USH, HARGIS, ROBT, 506 WASHINGTON ST CANNELTON 47520	GP	222	CAGLE, BOB, R, BOX 155 NEW PALESTINE 46163	GP	110
USH, JACK, ARROWSMITH, 405 LIFE BLDG LAFAYETTE 47901	AN	286	CAHN, HUGO, M, 6416 HOOVER RD APT D INDIANAPOLIS 46260	OS	134
USH, ROBT, WILLITS, BARTHOLOMEW COUNTY HOSPITAL COLUMBUS 47201	PTH	014	CAHN, PETER, H, 50 E 91ST SUITE 202 INDIANAPOLIS 46260	OPH	134
BUTLER, GEROLD, THOMAS, 5675 S EAST ST INDIANAPOLIS 46227	PD	134	CAIN, DAVID, ROBINSON, 1912 BUNDY AVE NEW CASTLE 47362	GP	122
BUTLER, JOHN, OLIN, 4949 CARSON AVE INDIANAPOLIS 46227	IM	134	CAIN, JEFFREY, L, 1400 HUDSON ELKHART 46514	OBG	070
BUTLER, RICHARD, MARKLAND, 3001 WOODGATE WAY RICHMOND 47374	DR	314	CAJACOB, MELVILLE, EDWARD, 1000 S 6TH ST TERRE HAUTE 47807	GP	298
BUTTERWORTH, JOS, CHAS, 3266 N MERIDIAN ST INDIANAPOLIS 46208	U	134	CALDWELL, MARILYN, R, 111 E 53D ST INDIANAPOLIS 46220	P	134
BUTTS, MILTON, A, 118 N WALNUT ST SOUTH BEND 46628	GP	258	CALDWELL, MILTON, VICTOR, 6151 CLINTON RD TERRE HAUTE 47805	R	298
BUYER, RICHARD, 6111 HARRISON STREET MERRILLVILLE 46410	IM	174	CALHOON, JOHN, PAUL, 1000 EAST MAIN ST DANVILLE 46122	R	118
BYLER, JOHN, J, 1002 LINCOLN WAY WEST SOUTH BEND 46616	GP	258	CALISTO, RUBEN, A, U S 24 WEST LOGANSPOUT 46947	GP	030
BYLLESBY, JOYCE, ELAINE, BOX 111 CRAWFORDSVILLE 47933	PTH	198	CALLAND, SABRA, K WETZLER, 8932 WICKHAM RD INDIANAPOLIS 46260	P	134
BYRNE, DAVID, ALLEN, 727 W 1ST ST BLOOMINGTON 47401	D	214	CALLI, LOUIS, JAMES, 408 S STATE ST NORTH VERNON 47265	GP	140
BYRNE, ROBT, JOS, 207 N MAIN ST BICKNELL 47512	GP	162	CALVERT, RAYMOND, RICE, R R 2 BOX 487 MONTICELLO 47960	OPH	286

CAMACHO, ERNESTO, M, 242 WEST ADAMS P O BOX 160 CHANDLER 47610	GP	306	CARLBERG, DALE, LEVAN, 226 EAST MAPLE ST JEFFERSONVILLE 47130	GP	03
CAMARATA, JAMES, CHAS, 1270 DOGWOOD COURT MARION 46952	DR	098	CARLSON, RALPH, FREDERICK, 611 HARRIET ST EVANSVILLE 47710	TS	29
CAMPAGNA, EDWARD, A, 3406 GUTHRIE ST EAST CHICAGO 46312	PH	174	CARMODY, RAYMOND, F, 5284 BROADWAY GARY 46408	OPH	17
CAMPBELL, FRANK, 1302 MADISON AVE ANDERSON 46011	GP	186	CARPENTER, BENNIE, F, 123 N COURT ST CROWN POINT 46307	IM	17
CAMPBELL, H, EDWIN, 8402 HARCOURT RD INDIANAPOLIS 46260	OBG	134	CARPENTER, DONALD, JACK, 600 SYCAMORE BLDG TERRE HAUTE 47907	OPH	29
CAMPBELL, PATRICK, B, 605 OAKLAND AVE ELKHART 46514	PD	070	CARPENTER, JAMES, BEDFORD, 49 N 26TH ST LAFAYETTE 47904	GP	286
CAMPBELL, RICHARD, WM, 3625 EAST 71ST INDIANAPOLIS 46220	CD	134	CARPENTIER, JAMES, ROBT, 900 I ST LA PORTE 46350	IM	178
CAMPBELL, ROBT, L, I U MEDICAL CTR INDIANAPOLIS 46202	NS	134	CARR, JOE, HENDERSON, HENRYVILLE 47126	GP	034
CAMPBELL, WM, THOS, 615 W 1ST ST BLOOMINGTON 47401	AN	214	CARREL, EDSON, DREW, 3133 WAYSIDE LANE ANDERSON 46011	ORS	186
CANNON, DANL, HUMPHREYS, 1201 E SPRING ST NEW ALBANY 47150	FP	078	CARREL, FRANCIS, EDSON, 6705 KANATA FORT WAYNE 46805	EM	286
CANNON, DAVID, R, 1220 MISSOURI AVE JEFFERSONVILLE 47130	R	034	CARROLL, BERTHA, ROSE, 4 JEWETT LANE SOUTH HADLEY MA 01075	OS	286
CANTWELL, EDGAR, RICHARD, P O BOX 979 VINCENNES 47591	OPH	162	CARROLL, JOHN, CLAYSON, 226 S 2D ST DECATUR 46733	GS	010
CAPELLO, WILLIAM, N, 1100 W MICHIGAN STREET INDIANAPOLIS 46202	ORS	134	CARROLL, MARY, E DAVIS, 124 N MAIN ST CROWN POINT 46307	GP	174
CAPLIN, IRVIN, 1815 N CAPITOL AVE INDIANAPOLIS 46202	A	134	CARTER, ARNOLD, LAWRENCE, 3400 BOWMAN AVE MUNCIE 47304	FP	062
CAPUTI, SAVERIO, 534 TURTLE CREEK N D INDIANAPOLIS 46227	R	134	CARTER, CHAS, BENJ, 5470 EAST 16TH ST INDIANAPOLIS 46218	NEP	134
CARAS, JOHN, ANTHONY, 5506 E 16TH #27 INDIANAPOLIS 46218	IM	134	CARTER, EUNICE, M MAIER, 585 SHERIDAN RD NOBLESVILLE 46060	PD	106
CARBERRY, GEO, AUGUST, 6111 HARRISON ST MERRILLVILLE 46410	OBG	174	CARTER, F, R NICHOLAS, 124 S JACOB SOUTH BEND 46617	PH	258
CAREY, JOHN, ALBERT, 2964 W 11TH ST GARY 46404	GP	174	CARTER, JAMES, EDWARD, 1100 W MICHIGAN ST INDIANAPOLIS 46202	OBG	134

ARTER,JEAN,VAL, 130 N MAIN ST TIPTON 46072	GP	290	CHA,JIN,SUCK, 7905 CALUMET MUNSTER 46321	OBG	174
ARTER,JOHN,OREN, 295 S WISCONSIN ST HOBART 46342	GP	174	CHABENNE,BAHJAT,S, 1213 N ARLINGTON INDIANAPOLIS 46219	GS	134
ARTWRIGHT,GLEN,WILLARD, 2600 GREENBUSH LAFAYETTE 47902	PD	286	CHAE,THOS,C, 7905 CALUMET AVE MUNSTER 46321		174
ASEY,STANLEY,MC CLURE, 1465 N LAFONTAINE ST HUNTINGTON 46750	GP	130	CHALLMAN,WM,BOWER, 715 1ST AVE STE 22 EVANSVILLE 47710	GP	296
ASSADY,J,VERNAL, 208 SHERLAND BLDG SOUTH BEND 46601	OPH	258	CHAMBERLAIN,DONALD,S, 919 E JEFFERSON STE 207 SOUTH BEND 46622	R	258
ASSADY,JAMES,EDWIN, 3121 BIRCH CANYON DRIVE CARMEL 46032		134	CHAMBERS,ALAN,R, 103 THREE RIVERS E FORT WAYNE 46802		082
ASSADY,JOHN,RUE, 208 SHERLAND BLDG SOUTH BEND 46601	OPH	258	CHAMBERS,CAROL,RUDOLPH, CHAMBERS MED CLINIC INC UNION CITY 47390	FP	246
ASSIM,RECHAD,M, P O BOX 2507 ELKHART 46514	PD	070	CHAMBERS,DONALD,CALVERT, 1301 S HARRISON ST FORT WAYNE 46802	PTH	082
ASTRO,IGNACIO,B, 685 WANDA ST SCOTTSBURG 47170	GS	262	CHAMBERS,LEROY,BAKER, CHAMBERS MED CLINIC UNION CITY 47390	GP	246
ASTUERAS,FLOR,TAYLAN, P O BOX 428 SALEM 47167	GP	310	CHAMBERS,RICHARD,KELLY, 5113 TORNHILL LANE ANDERSON 46011	IM	186
CATTELL,LEE,M, 555 FOREST BLVD INDIANAPOLIS 46240	OKS	134	CHAMBLEE,ROLAND,W, 336 N NOTRE DAME ST SOUTH BEND 46617	GP	258
CAUDILL,RODNEY,C, P O BOX 427 YORKTOWN 47396	P	062	CHANDLER,JAMES,DUNCAN, 125 BAUM ST AVILLA 46710	FP	206
CAVINS,ALEXANDER,W, R R 25 BOX 172 TERRE HAUTE 47802	GYN	298	CHANDLER,LEON,HARVEY, 112 E LINCOLN AVE GOSHEN 46526	GS	070
CAVINS,JOHN,ALEXANDER, 6202 N SHERMAN DR INDIANAPOLIS 46220	HEM	134	CHANG,IL,WOONG, ROSS CLINIC 6111 HARRISON ST MERRILLVILLE 46410	IM	174
CAYLOR,CHAS,H, 303 S MAIN ST BLUFFTON 46714	U	318	CHAPMAN,WM,EDWARD, 3266 N MERIDIAN ST INDIANAPOLIS 46208	U	134
CAYLOR,HAROLD,DELOS, 303 S MAIN ST BLUFFTON 46714	GS	318	CHAPPEL,ALFRED,TRUMAN, 901 N MAIN ST FRANKLIN 46131	GP	158
CAYLOR,TRUMAN,E, 303 S MAIN ST BLUFFTON 46714	U	318	CHASE,JAMES,ALLAN, 1635 BROADWAY FORT WAYNE 46804	OM	082
CESPEDES,CARLOS,ALBERTO, 101 N GRIFFITH BLVD GRIFFITH 46319	GS	174	CHATTIN,HERBEKT,ODELL, 729 MAIN ST VINCENNES 47591	GP	162

CHATTIN,ROBT,EARL, 102 WOOD LOOGOOTEE 47553	GP	046	CHMIELEWSKI,STANLEY,ROBT, 2519 EAST MAIN ST RICHMOND 47374	OPH	31
CHATTIN,WM,R, 5430 E 21ST INDIANAPOLIS 46218	PD	134	CHO,HUN-KOO, 513 N MICHIGAN ST SOUTH BEND 46601	OBG	25
CHAU,ANDREW,YIU-SUEN, 1645 N 7TH ST TERRE HAUTE 47804	GS	298	CHO,SUK-IN, 9129 SOUTHWOOD DR MUNSTER 46321	IM	17
CHAVEZ,MAURO,EMIGDIO, 2840 N HIGH SCHOOL RD SPEEDWAY 46224	UBG	134	CHOI,STEPHEN,S, 402 S BERKLEY RD KOKOMO 46901	ORS	12
CHEEK,JACK,ALLAN, 401 S E SIXTH ST EVANSVILLE 47710	PD	296	CHONA,ALFRED, 3210 GLEN HILLS DR MUNSTER 46321	GP	17
CHEN,JAMES,Z W, 2634 JAY COURT INDIANAPOLIS 46229	TR	134	CHOSLOVSKY,SYDNEY, METHODIST HOSP GARY 46402	R	17
CHEN,KO,KUEI, 7975 HILLCREST RD INDIANAPOLIS 46240	PA	134	CHRISTIE,MARVIN,CRANE, 3340 E LORETTA INDIANAPOLIS 46227	GP	13
CHEN,SHU-FANG, 6111 HARRISON ST MERRILLVILLE 46410		174	CHRONIAK,WALTER, 41 N SHORTRIDGE RD INDIANAPOLIS 46219	IM	13
CHEN,TZENG-CHIH, 421 CHESTNUT ST EVANSVILLE 47713	IM	296	CHU,JOHNSON,C S, LOGANSPOET STATE HOSP LOGANSPOET 46947	P	030
CHENG,SYLVIA,SIU-FAN, SOUTHEASTERN MED CTR WALTON 46994	P	030	CHUA,FARIDA,ISIP, 7895 BOWY MERRILLVILLE 46410		174
CHEMEL,IVAN,LEONARD, 7905 CALUMET AVE MUNSTER 46321	DR	174	CHUA,FELIPE,S, 7895 BROADWAY MERRILLVILLE 46410	CDS	174
CHERNISH,STANLEY,M, 4403 RADNOR RD INDIANAPOLIS 46206	OS	134	CHUA,GONZALO,TAN, 655 YOSEMITE DR INDIANAPOLIS 46217	R	134
CHEUNG,AMY,A, 6484 CHESTER AVE INDIANAPOLIS 46260	PD	134	CHUBE,DAVID,DEMARET, 1649 BROADWAY GARY 46407	GP	174
CHEVALIER,ROBT,BURRIS, 101 N 17TH ST ST FRANCIS HOS BEECH GROVE 46107	IM	134	CHUNG,DUCK,JAE, 7550 HOHMAN MUNSTER 46321	OBG	174
CHIP,JEROLD,NORMAN, 7863 BROADWAY MERRILLVILLE 46410	CD	174	CHUNG,IL,SUNG, 4019 COLUMBUS AVE ANDERSON 46014	GP	186
CHIU,FANG,LUKE, 1507 NORTH MAIN ST FRANKLIN 46131	OBG	158	CLARK,CHAS,MALCOLM, 1481 WEST 10TH ST INDIANAPOLIS 46202	IM	134
CHIVAPRUK,CHARAT, 3707 W 108TH ST CROWN POINT 46307	AN	174	CLARK,EDWARD,EDMUND, 3363 NORTH CENTRAL AVE INDIANAPOLIS 46205	GP	134
CHIVINGTON,PAUL,V, 1815 N CAPITOL AVE RM 414 INDIANAPOLIS 46202	D	134	CLARK,ERIC,DANL, 100 MEADOW DR DANVILLE 46122	GP	118

LARK, GEO, ALEXANDER, 50 E 91ST ST INDIANAPOLIS 46240	OPH	134	CLINE, KENNETH, LAMAR, BOX 57 WYATT 46595	GP	258
LARK, JACK, PROW, 303 S HUNTINGTON ST SYRACUSE 46567	FP	070	CLOUSE, JOHN, FRANKLIN, BALL STATE UNIV HLTH SERVICE MUNCIE 47306	GP	062
LARK, LAWSON, J, 3736 N DELAWARE ST INDIANAPOLIS 46205	OBG	134	CLUNIE, WM, ADAMS, 323 W PARK DR HUNTINGTON 46750	OPH	130
LARK, ROBT, M, 2809 GOODMAN AVE MUNCIE 47304	OPH	062	CLUTTER, ROBT, EDWARD, 6505 E 82ND STREET INDIANAPOLIS 46250	FP	106
LARK, THOS, W, 421 CHESTNUT EVANSVILLE 47713	IM	296	COBB, CLARENCE, M, 3232 NORTH MERIDIAN ST INDIANAPOLIS 46208	PTH	134
LARK, WM, B, 435 SPRING ST JEFFERSONVILLE 47130	GP	034	COBLE, FRANK, HAROLD, 51 S 8TH ST RICHMOND 47374	OPH	314
LARK, WM, HEMENWAY, 520 SHERLAND BLDG SOUTH BEND 46601	OTO	258	COCHRAN, HARRY, ADAM, 706 NIGHTFALL RD FORT WAYNE 46819	OS	082
LARK, WM, RUSSELL, 3622 SOUTH CALHOUN ST FORT WAYNE 46807	GP	082	COCKRELL, DALE, KETE, 8224 MADISON AVE INDIANAPOLIS 46227	GP	134
LARK, WM, RUSSELL, 2828 FAIRFIELD AVE FORT WAYNE 46807	IM	082	CODDENS, AVERY, L, STATE RD 55 FOWLER 47944	GP	018
LARKSON, CLARENCE, G, 300 GREENBRIER DRIVE RICHMOND 47374	FP	314	COFFEL, MELVIN, HOOKER, 214 BUNTIN ST SUITE 104 VINCENNES 47591	GPH	162
CLARO, JOS, JOHN, 2815 INDIANAPOLIS BLVD WHITING 46394	AM	174	COFIELD, DONALD, DEAN, 351 S LINCOLN BLOOMINGTON 47401	OPH	214
CLASSEN, PETE, R C, 23919 U S 33 E ELKHART 46514	GP	070	COGGESHALL, WARREN, EVART, 3524 N MERIDIAN INDIANAPOLIS 46208	CD	134
CLAY, ELEANOR, 3402 GROVE PL COLUMBUS 47201	IM	014	COHEN, HYMAN, LEWIS, 600 GRANT ST GARY 46402	N	230
CLEARY, ROBERT, E, 9048 YELLOWWOOD COURT INDIANAPOLIS 46260	OBG	134	COHEN, IRVING, 645 E MAIN ST PLAINFIELD 46168	FP	118
CLEMENTE, JOSE, PERALEJO, 4400 SOUTH B ST RICHMOND 47374	GP	314	COHN, ALVIN, FRANK, 1338 WEST CURRY RD GREENWOOD 46142	AN	134
CLEVINGER, WM, GERALD, ST JOSEPH MEMORIAL HOSP 1907 W SYCAMORE ST KOKOMO 46901	PTH	126	COLE, LARRY, GENE, 1003 EAST SMITH STREET YORKTOWN 47396	FP	062
CLINE, CHAS, THEODORE, 2600 GREENBUSH ST LAFAYETTE 47904	GE	286	COLEMAN, FLOYD, BUTLER, WATERLOO 46793	GP	058
CLINE, DONALD, LEE, 2020 WEST 86TH ST INDIANAPOLIS 46260	OBG	134	COLLIER, JOHN, WM, 2900 W 16TH ST BEDFORD 47421	FP	182

COLLINS, HUBERT, LOWELL, 6745 E 10TH ST INDIANAPOLIS 46219	GP	134	CONNERLY, PATRICK, WM, 604 EAST 11TH ST KUSHVILLE 46173	FP	25
COLLINS, JACK, TEMPEST, 303 S MAIN ST BLUFFTON 46714	CD	318	CONRAD, EVERETT, LEROY, 1207 E NATIONAL AVE BRAZIL 47834	GP	031
COLLINS, ROBT, CARL, 3440 N MERIDIAN INDIANAPOLIS 46208	GP	134	CONRAD, HENRY, WEBB, 370 BIELBY RD LAWRENCEBURG 47025	FP	051
COLVIN, ROBT, CLYDE, 333 STATE ST NEWBURGH 47630	GP	306	CONROY, MICHAEL, DENNISON, 3123 MISHAWAKA AVE SOUTH BEND 46615	FP	258
COMBS, HERMAN, TOW, 807 W INDIANA ST EVANSVILLE 47710	GP	296	CONSTAN, EVAN, BOX 473 WESTVILLE 46391	P	178
COMBS, JOHN, HAROLD, R R 3 BLOOMFIELD 47424	AN	296	CUNWAY, GLENN, 2235 S GARFIELD DRIVE INDIANAPOLIS 46203		134
COMEAU, WM, JOS, 918 HAWTHORNE RD MARION 46952	R	098	CONWAY, LOUIS, WM, 2600 GREENBUSH ST LAFAYETTE 47904	NS	286
COMPTON, GEO, LEONARD, 219 N INDEPENDENCE ST TIPTON 46072	GP	290	CONWAY, THOS, J, 221 S 6TH ST TERRE HAUTE 47807	PD	298
COMPTON, WALTER, AMES, 2225 GREENLEAF BLVD ELKHART 46514	OS	070	CONWAY, WILLIAM, F, 5468 N MICHIGAN ROAD INDIANAPOLIS 46208	PD	134
CONKLIN, JAMES, OLIVER, 502 TRIBUNE BLDG TERRE HAUTE 47801	GS	298	COOK, DEAN, L, 919 EAST JEFFERSON SOUTH BEND 46622	R	258
CONKLIN, RAYMOND, LE ROY, 215 SWANSON CIRCLE W SOUTH BEND 46615	OM	070	COOK, GORDON, C, 1620 SOUTHWOOD AVE SOUTH BEND 46615	OBG	258
CONLEY, JOHN, ELLIS, 620 W BERRY ST FORT WAYNE 46802	GP	082	COOK, IAN, HARPER, 4112 ARLINGTON AVE FORT WAYNE 46807	GS	082
CONLEY, THOS, MARION, 2811 DELLWOOD DRIVE KOKOMO 46901	OBG	126	COOK, MELVIN, DUANE, 1919 STATE ST 202 NEW ALBANY 47150	GS	078
CONNELL, VACTOR, O, 114 N WASHING ST BOURBON 46504	GP	190	COOK, ROBT, GIBSON, 303 S MAIN ST BLUFFTON 46714	OTO	318
CONNELLY, JERRY, HUBBARD, 4306 LAKE ST FORT WAYNE 46805	GP	082	COOK, THOMAS, LYNN, 25 JOHNSON PLACE EVANSVILLE 47714	DR	296
CONNELLY, RICHARD, DONALD, 4310 LAKE AVE FORT WAYNE 46805	GP	082	COOKSON, LAWRENCE, UPJOHN, 360 W 62ND ST INDIANAPOLIS 46240	R	134
CONNER, ROBT, ALLISON, 2828 FAIRFIELD AVE FORT WAYNE 46807	R	082	COOLEY, PAUL, PHILLIP, 103 S BROADWAY BOX 308 YORKTOWN 47396	GP	062
CONNERLEY, MARION, L, 107 S 7TH ST TERRE HAUTE 47801	GS	298	COONEY, CHAS, JOHN, 527 W BERRY ST FORT WAYNE 46802	U	082

DOONS, FREDERICK, WM, 2115 EAST 3RD ST BLOOMINGTON 47401	P	214	COSTELLO, ALBERT, J, 110 RIDGE RD MUNSTER 46321	OBG	174
DOONS, RITCHIE, 404 WEST CAMP LEBANON 46052	GP	022	COSTIN, ROBT, LEE, 301 EAST 38TH ST INDIANAPOLIS 46205	PTH	134
DOOPER, B, TRENT, 155 8TH ST ROANOKE 46783	FP	082	COTTER, EDWARD, RICHARD, 2415 169TH ST HAMMOND 46323	GS	174
DOOPER, DANL, F, 1815 N CAPITOL AVE INDIANAPOLIS 46202	NS	134	COTTOM, DAVID, LEE, 801 ST MARYS DRIVE SUITE 501 NEPHROLOGY ASSOCIATES EVANSVILLE 47715	IM	296
DOOPER, JOHN, FREDRICK, 3022 S MADISON MUNCIE 47302	GP	062	COTTRELL, ROBT, FRANKLIN, 5800 FAIRFIELD AVE FORT WAYNE 46807	AN	082
DOOPER, JOHN, IRWIN, 124 WEST 3RD ST MADISON 47250	D	150	COUGHENOUR, J, ROBT, 534 TURTLE CREEK DR N INDIANAPOLIS 46227	GP	134
DOOPER, LEO, KENNETH, 504 BROADWAY STE 338 RM 333 GARY 46402	GS	174	COULON, THOS, FRANCIS, R R 6-15 FINLANDIA PL MUNCIE 47302	GS	062
DOOPER, WALLER, WALLACE, P O BOX 887 EVANSVILLE 47701	AN	296	COULTER, MERLIN, KENNETH, 2300 GILBERT MUNCIE 47303	FP	062
DOOPER, WM, EARL, 2760 25TH STREET COLUMBUS 47201	OTO	014	COUNTRYMAN, FRANK, W, 1815 N CAPITOL AVE INDIANAPOLIS 46202	P	134
DOOPER, DAVID, E, 3266 N MERIDIAN APT 404 INDIANAPOLIS 46208	OBG	134	COURSEY, JAMES, O, P O BOX 479 PLYMOUTH 46563	GP	190
DORCORAN, PATRICK, J V, P O BOX 3287 EVANSVILLE 47701	IM	296	COVALT, WENDELL, EARL, 2724 W NORTH ST MUNCIE 47303	GS	062
DORDANO, ANGEL, 2404 PENNSYLVANIA EVANSVILLE 47721	NTR	296	COVELL, HARRY, MENLO, 127 W 7TH ST AUBURN 46706	GP	058
DORMICAN, HERBERT, LEROY, 1400 HUDSON ST ELKHART 46514	OBG	070	COVEY, THOS, JAMES, RR 11 BOX 4448 VALPARAISO 46383	PD	230
DORNACCHIONE, MATTHEW, 741 CARROLLTON CT INDIANAPOLIS 46220	GP	134	COVINGTON, CONSTANCE, JOAN, 1101 GLENDALE VALPARAISO 46383	GP	230
DORTESE, JAMES, V, 3901 S EAST ST INDIANAPOLIS 46227	GP	134	COWAN, JOHN, THOS, 3124 EAST BLVD FORT WAYNE 46805	OBG	082
DORTESE, THOS, A, 5411 E 56TH ST INDIANAPOLIS 46226	D	134	COX, ALFRED, CHARLES, 51916 US 31 N SOUTH BEND 46637	GP	258
DORTESE, THOS, ANTHONY, 3901 S EAST ST INDIANAPOLIS 46227	GS	134	COX, LARRY, LA VON, 5900 BOOKER RD EVANSVILLE 47712	EM	296
DOSIO, JULIO, ELIO, 1206 SPRING ST JEFFERSONVILLE 47130	GP	034	COX, LEON, THOMPSON, 1210 E MAIN ST RICHMOND 47374	GP	314

COYNER, ALFRED, BRUCE, R D 1 CLARKS HILL 47930	GP	286	CREEK, JEAN, A, 1421 SARE RD BLOOMINGTON 47401	IM	210
CRABBE-FORBES, VIOLET, M, WOLCOTT 47995	GP	322	CRISE, JOHN, ROBT, 2674 PORTAGE MALL PORTAGE 46368	GP	230
CRAFT, KENNETH, L, 2245 S SHERIDAN INDIANAPOLIS 46203	A	134	CRIST, JOHN, R, 745 E 2ND ST MOUNT VERNON 47620	GP	234
CRAIG, ALEXANDER, F, 7751 CONIFER INDIANAPOLIS 46250	AN	134	CRISTEE, JAMES, WARREN, 400 8TH AVE TERRE HAUTE 47804	IM	298
CRAIG, REUBEN, ALLEN, 514 W SUPERIOR ST KOKOMO 46901	PD	126	CROCKETT, WAYNE, ALBERT, 1024 S 6TH ST TERRE HAUTE 47807	IM	298
CRAIG, RICHARD, MORTON, 2828 FAIRFIELD AVE FORT WAYNE 46807	R	082	CRON, WM, JAMES, 725 WEST 1ST STREET BLOOMINGTON 47401	D	214
CRAIG, ROBT, ALEXANDER, BOX 607 SYRACUSE 46567	GP	070	CRONIN, H, JOS, 7843 WINDCOMBE BLVD INDIANAPOLIS 46240	R	134
CRAMER, SAM, KEITH, 1303 N ARLINGTON INDIANAPOLIS 46219	IM	134	CROSBY, REID, CLIPP, 2900 W 16TH ST BEDFORD 47421	OBG	182
CRANE, DAVID, GOODRICH, 650 NORTH GIRLS SCHOOL ROAD INDIANAPOLIS 46224	P	214	CROSS, DAVID, GEO, ST VINCENT HOSP INDIANAPOLIS 46208	EM	134
CRATES, GORDON, COLVIN, DENVER MED CLINIC BOX 188 DENVER 46926	GP	194	CROSS, RICHARD, WESLEY, 600 E WINONA AVE WARSAW 46580	OBG	166
CRAVENS, FREDERICK, A, 7654 HOLLIDAY DR WEST INDIANAPOLIS 46260	OBG	134	CROSSIN, JAMES, ALOYSIUS, 1815 N CAPITAL INDIANAPOLIS 46202	GS	134
CRAVENS, ROBERT, E, 8402 HARCOURT RD SUITE 809 INDIANAPOLIS 46260	ORS	134	CROWDER, JAMES, H, 112 N SECTION ST SULLIVAN 47882	GP	282
CRAWFORD, JAMES, HARVEY, 611 HARRIET ST-STE 402 EVANSVILLE 47710	GP	296	CRUDDEN, CHAS, H, 6600 WASHINGTON AVE EVANSVILLE 47715	P	296
CRAWFORD, JOHN, A, 8402 HARCOURT RD APT 805 INDIANAPOLIS 46260	ORS	134	CUFF, STEVE, COLLEY, 700 W BERRY FORT WAYNE 46802	R	082
CRAWFORD, JOHN, N, 2200 LAKE AVE FORT WAYNE 46815	R	082	CULBERTSON, CLYDE, G, R R 4 NASHVILLE 47448	PTH	134
CRAWFORD, THEODORE, R, 201F BLUFFS CIRCLE NOBLESVILLE 46060	EM	126	CULBERTSON, KENNETH, LEE, 211 NORTH EDDY ST SOUTH BEND 46617	PD	258
CREASSER, CHAS, WM, 604 NORTH MICHIGAN ST SOUTH BEND 46601	AN	258	CULLISON, JOHN, L, BALL MEMORIAL HOSP MUNCIE 47303	IM	062
CREED, GARY, ST CLAIR, 7513 SOUTHEASTERN AVENUE INDIANAPOLIS 46239	GP	134	CULLNANE, CHRIS, WALTER, 2312 W FRANKLIN ST EVANSVILLE 47712	GS	296

ULP, JOHN, EWART, 2902 FAIRFIELD AVE FORT WAYNE 46807	DIA	082	DAGGY, JAMES, R, 47 S 24TH ST RICHMOND 47374	FP	314
UMMING, JAMES, ROOD, 8801 NORTH MERIDIAN ST NO 308 INDIANAPOLIS 46260	PD	134	DAHLING, FRED, WALDEMAR, DAHLING BLDG NEW HAVEN 46774	GP	082
UMMINS, DOUGLAS, F, R R 1 BRIARPATCH RD BARGERSVILLE 46106	AN	134	DAINKO, ALFRED, JOS, 915 W CHICAGO AVE EAST CHICAGO 46312	GS	174
UNNINGHAM, CAROLYN, ANN, WISHARD MEMORIAL HOSP 1001 W 10TH ST INDIANAPOLIS 46202	IM	134	DALEY, EDWARD, HENRY, 509 W HUNTERS DR APT B CARMEL 46032	AN	134
UNNINGHAM, ROBT, DANA, 500 WABASH AVE MARION 46952	IM	098	DALLAS, FRED, R, 1640 N RITTER ST INDIANAPOLIS 46218	U	134
URE, CHAS, WM, 2529 SANDCREST BLVD COLUMBUS 47201	NS	134	DALTON, NAOMI, LUCILLA, 2307 E 2ND ST APT 10 BLOOMINGTON 47401	OS	214
URE, ELMER, T, 801 ASHLAND AVE MUNCIE 47305	P	062	DALTON, WILSON, L, 10 NORTHRIDGE PK P O BOX 70 SHELBYVILLE 46176	GP	266
URETON, EDWARD, ERVINE, P O BOX 1149 BLOOMINGTON 47401	P	214	DALTON, WM, WARREN, P O BOX 618 INDIANAPOLIS 46206	OM	134
URRIE, ROBT, WM, 7106 BOHNKE DRIVE FORT WAYNE 46805	DR	082	DALY, JOS, M, 5969 SINGLETON ST INDIANAPOLIS 46227	PD	134
URRY, R, LOUIS, 5707 E 38TH ST INDIANAPOLIS 46218	GP	134	DALY, WALTER, JOS, INDIANA UNIV MED CTR INDIANAPOLIS 46202	IM	134
URTNER, MYRON, L, 222 N 6TH ST VINCENNES 47591	GS	162	DANIEL, GERALD, OWEN, P O BOX 2413 ANDERSON 46011	R	186
USICK, JAMES, ALAN, 11119 ST ANDREWS LANE CARMEL 46032	AN	134	DANIEL, JOHN, CARLTON, 531B VIA ESTRADA LAGUNA HILLS CA 92653	OS	134
USTODIO, CAMIA, ACEVEDO, 12501 S MOODY AVE PALOS HEIGHTS IL 60463	AN	174	DANIEL, ROBT, ALBERT, 427 S LAKE ST GARY 46403	PD	174
UTHBERT, MARVIN, P, 3266 NORTH MERIDIAN ST INDIANAPOLIS 46208	OPH	134	DANNACHER, WM, DENNIS, 400 ASH ST WABASH 46992	ABS	302
CZENKUSCH, HELEN, E GEYER, 2840 N HIGH SCHOOL RD SPEEDWAY 46224	PD	134	DARLING, DOROTHY, RUTH, 2403 WEST 63RD ST MERRILLVILLE 46410	AN	174
			DARNELL, JEFFREY, CHAS, 3829 E 126TH ST CARMEL 46032	IM	134
DAFTARY, ALI, AKBAR, R R 2 BOX 500G 16 WESTBROOK ACRE BATESVILLE 47006	IM	250	DARROCA, WM, CELIS, RICHMOND STATE HOSP RICHMOND 47374	P	314
DAFTARY, MOSTAFA, 333 EAST FIRST ST GREENSBURG 47240	GS	054	DAS, AMAL, KUMAR, 401 E REYNOLDS DR KOKOMO 46901	GP	126

DASHIELL, JAMES, RALPH, 6175 CRITTENDEN AVENUE INDIANAPOLIS 46220	ORS	134	DAVIS, HOWARD, B, 2600 GREENBUSH ST LAFAYETTE 47902	U	286
DATZMAN, BASIL, JOS, 103 W 18TH ST LA PORTE 46350	GP	178	DAVIS, JOHN, ALEXANDER, FLAT ROCK 47234	GP	266
DATZMAN, RICHARD, C, 2200 LAKE AVE SUITE 150 FORT WAYNE 46805	DR	082	DAVIS, KENNETH, DEYLEN, 801 ST MARYS DR EVANSVILLE 47715	ORS	296
DAUGHERTY, FOREST, DALE, 2600 SANDCREST BLVD COLUMBUS 47201	FP	014	DAVIS, MARGARET, MELVINA, 2603 W 42ND ST INDIANAPOLIS 46208	AN	134
DAUGHERTY, FRED, NEWTON, 120 W PIKE ST CRAWFORDSVILLE 47933	GP	196	DAVIS, MARVIN, ROBBINS, 908 WASHINGTON ST COLUMBUS 47201	GP	014
DAUGHERTY, H, SAYLER, 102 MEDICAL CENTER BLDG FORT WAYNE 46802	OTO	082	DAVIS, SAM, J, 115 N PENNSYLVANIA ST RM 1252 INDIANAPOLIS 46204	ORS	134
DAUGHERTY, WM, LOUIS, BOX 275 HUTSONVILLE IL 62433	GP	282	DAVIS, THOS, WM, P O BOX 270 WASHINGTON 47501	FP	046
DAUS, MILTON, J, 1654 WESTWOOD DRIVE ANDERSON 46011	GP	186	DAWKINS, PHILLIP, ROSS, 507 WEST 7TH ST JASPER 47546	IM	066
DAVID, DELFIN, PARAS, 4606 STRATFORD DR KOKOMO 46901	EM	126	DAY, WM, DURBIN CHAS, 410 S CHESTNUT SEYMOUR 47274	GP	138
DAVIDSON, CHAS, O'DELL, 2200 GRANT ST GARY 46404	OBG	174	DAYSON, LOUIE, OTTO, 218 SECURITY BANK BLDG VINCENNES 47591	IM	162
DAVIDSON, DALE, A, 25 E 40TH STT NO 7 G INDIANAPOLIS 46205	PS	134	DE ARMOND, ALBERT, M, 1815 N CAPITOL AVE INDIANAPOLIS 46202	P	134
DAVIDSON, HAROLD, HALL, 421 CHESTNUT ST EVANSVILLE 47713	OBG	296	DE BROTA, JOHN, 3266 N MERIDIAN INDIANAPOLIS 46208	AN	134
DAVIS, BENNIE, LEON, 2615 N CAPITOL AVE INDIANAPOLIS 46208	U	134	DE FRIES, JOHN, J, NEW PARIS 46553	GP	070
DAVIS, CARL, MARLOW, R R 13 VALPARAISO 46383	GP	230	DE JESUS, JOSE, R, 120 W WASHINGTON PLYMOUTH 46563	CD	190
DAVIS, CLAUDE, E, 402 B NORTH WAYNE STREET ANGOLA 46703	GS	278	DE LA COTERA, FEDERICO, G, 7905 CALUMET AVE MUNSTER 46321	GP	174
DAVIS, EDWARD, ANDREW, 3014 ARDMORE TRAIL SOUTH BEND 46628	FP	258	DE LA PAZ, OSCAR, GUEVARA, 500 W LINCOLN HWY MERRILLVILLE 46410	U	174
DAVIS, EVERETT, J, 4700 LAKECOURT INDIANAPOLIS 46227	R	134	DE LEON, EDILBERTO, S, 29 EAST MAIN ST PERU 46970	AN	194
DAVIS, GRAYSON, B, 2500 FERRY ST STE 150 LAFAYETTE 47904	GP	286	DE MELO, LUIZ, PEREIRA, 5490 BROADWAY MERRILLVILLE 46410	ORS	174
			DE MOTTE, CAMILIUS, B, BOX 44 GREENWOOD 46142	OS	134

DE NAUT, JAMES, F, 4 N HEATON ST KNOX 46534	GP	274	DEL ROSARIO, PEDRO, G, 121 W 8TH ST ROCHESTER 46975	GP	090
DE PALMA, BRUNO, DEARBORN COUNTY HOSPITAL LAWRENCEBURG 47025	R	050	DELUMPA, RUSTICA, Y CARLOS, 802 LA PORTE VALPARAISO 46383	PD	230
DE PORTER, LOUIS, ALPHONSE, 7905 CALUMET AVE MUNSTER 46321	GP	174	DELUMPA, VINCENTE, PALMA, 802 LA PORTE AVE VALPARAISO 46383	U	230
DE ROSA, GUY, PAUL, 29 RIDGEWAY BROWNSBURG 46112	ORS	134	DENHAM, ROBERT, H, 109 S ST LOUIS BLVD SOUTH BEND 46617	ORS	258
DE WESTER, GERALD, MAYSON, GREENWOOD MEDICAL GROUP 100 N MADISON AVE GREENWOOD 46142	FP	134	DENNISON, KUMPOL, 1000 E 80TH NO 525 MERRILLVILLE 46410	GS	174
DEACON, WALTER, E, 5037 GUION RD INDIANAPOLIS 46254	PH	134	DENNY, FORREST, L, 3351 W 10TH ST INDIANAPOLIS 46222	FP	134
DEAL, ELEANOR, H B, 4917 W 15TH ST SPEEDWAY 46224	GP	134	DENNY, JAMES, WESLEY, 25 N RITTER AVE INDIANAPOLIS 46219	GP	134
DEAN, DONALD, IRVIN, 4TH AND MAIN RUSHVILLE 46173	OPH	254	DENNY, MELVIN, HARVEY, 1207 VAN BUSKIRK RD ANDERSON 46011	AN	186
DEAN, FREDERICK, KENNETH, 919 E JEFFERSON BLVD SOUTH BEND 46622	R	258	DENTON, LARKIN, D, 128 S HOWARD ST GREENTOWN 46936	EM	126
DEANOVIC, FRANK, WM, 1400 CHESTER BLVD RICHMOND 47374	D	314	DENZER, EDWARD, K, 540 SCENIC DRIVE EVANSVILLE 47715	GP	296
DEARMIN, ROBT, MASON, 6616 SPRING MILL RD INDIANAPOLIS 46260	OTO	134	DENZER, WM, OLIVER, 2329 CHANDLER EVANSVILLE 47714	GP	296
DECKER, JEFFRY, R, 3010 EAST STATE BLVD FORT WAYNE 46805	D	082	DEOGRACIAS, FRANCISCO, D, EDINBURG MED CLINIC EDINBURG 46124	GS	158
DEEN, CHRISTOPHER, 6111 HARRISON MERRILLVILLE 46410	OPH	174	DEOGRACIAS, MONICA, D, 813 BOULDER RD INDIANAPOLIS 46217	AN	134
DEERY, MICHAEL, FRANCIS, 921 LAKE SHORE DR CULVER 46511	GP	190	DEPPE, CHAS, FREDERICK, 301 E JEFFERSON ST FRANKLIN 46131	GP	158
DEEVER, JOHN, WILKIN, 4131 SHELBY ST INDIANAPOLIS 46227	OBG	134	DERHAMMER, GEO, LEWIS, R R 5 BOX 343 MONTICELLO 47960	GP	286
DEHNER, JOHN, ROSS, 212 SOUTH 22ND ST RICHMOND 47374	TR	314	DERSCH, DAVID, MATHEWS, 2501 W JACKSON MUNCIE 47303	OBG	062
DEITCH, ROBT, DAVID, 1500 ALBANY ST SUITE 801 BEECH GROVE 46107	OPH	134	DESTER, HERBERT, EDGAR, 424 W COMPROMISE ST BERNE 46711	GP	010
DEITSCH, HOWARD, C, 1020 N J ST RICHMOND 47374	GP	314	DETTLOFF, FREDERICK, R, 407 MELROSE AVE GREENCASTLE 46135	GP	242

DETTMER,ROBT,WAYNE, 5105 WORTHMAN COURT FORT WAYNE 46807	NEP	082	DILL,MYRON,K, 3120 N MERIDIAN ST INDIANAPOLIS 46208	IM	134
DEUPREE,WM,DWIGHT, 23 W HENDRICKS ST SHELBYVILLE 46176	PD	266	DILLMAN,CARL,EDWARD, BEAVER AND OAK STS CORYDON 47112	GP	114
DEUR,JULIUS,JAY, 1011 COLUMBIA ST LAFAYETTE 47901	IM	286	DILLON,GARY,P, DUEMLING CLINIC 2828 FAIRFIELD AVE FORT WAYNE 46807	D	082
DEVETSKI,ROBT,LLOYD, AMER NAT'L BANK BLDG STE 1812 SOUTH BEND 46601	IM	258	DILTS,ROBT,LOUIS, 9041 BRIARCLIFT ROAD INDIANAPOLIS 46256	GP	134
DEW,DANL,CHING-YEE, ELKHART CLINIC ELKHART 46514	GS	070	DIMAILIG,GREGORIO,H, 1802 COLUMBUS EAST CHICAGO 46312	GP	174
DHANA,SRIKIETR, 6111 HARRISON MERRILLVILLE 46410	PDC	174	DIMITROFF,LAMBRO, 500 RIVER OAKS DR CALUMET CITY IL 60409	GP	174
DIAMOND,HOWARD,MICHAEL, 7905 CALUMET AVE MUNSTER 46321	U	174	DINGLE,PAUL,ELLSWORTH, 127 MED ARTS BLDG RICHMOND 47374	Obs	314
DIAN,AUGUST,JOS, 1517 STODGILL ROAD BLUFFTON 46714	P	178	DINGLEY,ALBERT,F, 109 S ST LOUIS AVE SOUTH BEND 46617	ORS	258
DIAN,DONALD,AUGUST, 303 SOUTH MAIN ST BLUFFTON 46714	P	318	DININGER,WM,STRAUGHN, 303 S MAIN ST WINCHESTER 47394	GP	246
DICK,WM,HENRY, 2020 W 86TH ST STE 307 INDIANAPOLIS 46260	IM	134	DITTMER,JACK,EDWARD, 60 JEFFERSON ST VALPARAISO 46383	GP	230
DICKERSON,W,MARTIN, 1114 O'CONNOR BLVD MONTICELLO 47960	EM	322	DITTMER,THOS,LYLE, 60 JEFFERSON ST VALPARAISO 46383	GS	230
DICKS,ROBT,EVAN, 8242 S MADISON AVENUE INDIANAPOLIS 46227	FP	134	DIVCIC,BORIVOJ,SRETEN, 701 WALL ST VALPARAISO 46383	P	174
DICKSON,CAROLYN,H LUCAS, 501 N WEST ST INDIANAPOLIS 46202	GP	134	DIZON,BELEN,RODRIGUEZ, 8149 KRAAY AVE MUNSTER 46321	AN	174
DICKSON,DALE,DONALD, R R 6 BOX 16 GREENSBURG 47240	GP	054	DIZON,GUALBERTO,REYES, 800 MAC ARTHUR BLVD MUNSTER 46321	GP	174
DIECKMAN,HERBERT,S, 3700 BELLMEADE EVANSVILLE 47715	A	296	DIZON,MIGUEL,B, ST VINCENT HOSPITAL 2001 WEST 86TH ST INDIANAPOLIS 46260	NM	134
DIEHL,EARL,H, 303 SOUTH MAIN ST BLUFFTON 46714	GE	318	DIZON,RUSTICO,HIPOLITO, DEARBORN CO HOSP LAWRENCEBURG 47025	AN	050
DIETZ,DAVID,JACKSON, 2810 ETHEL MUNCIE 47304	FP	062	DOAN,JOHN,ELDRIDGE, 222 S 2D ST DECATUR 46733	GP	010
DILL,CHAS,WM, 3655 S SHERMAN DR BEECH GROVE 46107	GP	134	DODD,ROBERTS,K, 2042 LINCOLN AVE EVANSVILLE 47714	GS	296

ODD,ROBT,DARR, 2311 MIAMI ST SOUTH BEND 46614	GP	258	DOUGHTY,SAML,R, WINDRIDGE OFFICE BLDG NO 115 5435 EMERSON WAY NORTH INDIANAPOLIS 46226	AN	134
ODDS,JAMES,URI, 227 W MAIN ST HARTFORD CITY 47348	GP	062	DOUGLAS,WM,THOS, 3266 N MERIDIAN STE 407 INDIANAPOLIS 46208	AN	134
ODDS,WEMPLE, 414 EAST PIKE ST CRAWFORDSVILLE 47933	R	198	DOUMANIAN,HERATCH,O, 540 TYLER ST GARY 46402	R	174
ODERMANN,PAUL,E, 1751 N JEFFERSON ST HUNTINGTON 46750	GS	136	DOVEY,EDWARD,G, 513 OAKLAND AVE ELKHART 46514	U	070
ODERTY,RAYMOND,JAMES, 47 W 68TH PL MERRILLVILLE 46410	GP	174	DOWD,JOS,A, 525 W HAMPTON INDIANAPOLIS 46208	IM	134
OLAN,PATRICK,ANTHONY, 9038 CHESTNUT CT INDIANAPOLIS 46260	R	134	DOWELL,ANTHONY,REED, 420 WASHINGTON ST MUNCIE 47305	PUD	062
OLEZAL,BERNARD,J, 425 WEST NORTH SHORE DR SOUTH BEND 46616	GP	258	DOWNER,LUTHER,H, P O BOX 952 EVANSVILLE 47706	GP	296
OMINGO,RICARDO,C, DOMINGO BLDG GREENSBURG 47240	GP	054	DOWNES,KENNETH,R, 598 COVENTRY WAY NORTH HARBOUR NOBLESVILLE 46060	OM	134
ONAHUE,GEO,RICHARD, 250 SOUTH OCEAN BLVD 7C BOCA RATON FL 33432	GP	286	DRAKE,DALE,WILFRED, ST MARYS HOSPITAL EVANSVILLE 47715	AN	296
ONALDSON,FRANK,COOMBS, 2009 BROWN ST ANDERSON 46014	OBG	186	DRAKE,ELLERY,THEODORE, 1995 SUNRISE ST MARTINSVILLE 46151	PM	202
ONALDSON,MILES,WARREN, 706 RIVER DR MARION 46952	GP	098	DRAKE,JAMES,RICHARD, 2304 MERIDIAN ST ANDERSON 46014	FP	186
ONATO,ALBERT,MARIO, 2860 CHURCHMAN AVE INDIANAPOLIS 46203	FP	134	DRAKE,JOHN,CALVIN, 604 ANDERSON BANK BLDG ANDERSON 46016	GS	186
ONEFF,RONALD,HAROLD, 5490 BROADWAY PLAZA MERRILLVILLE 46410	U	174	DRAKE,MARION,CLIFFORD, 1201 MAIN ST ELWOOD 46036	GP	186
ONESA,ANTONIO,BRAGANZA, 3030 LAKE AVE FORT WAYNE 46805	NS	082	DREW,DANL,CONNOR, JASPER MED ARTS BLDG JASPER 47546	FP	066
ONOHUE,JOHN,PATRICK, 1100 W MICHIGAN ST INDIANAPOLIS 46202	U	134	DRUMMY,WM,WALLACE, 436 S 30TH ST TERRE HAUTE 47803	IM	298
ONOVAN,THOS,GEIGER, 421 CHESTNUT ST EVANSVILLE 47713	IM	296	DRYDEN,GALE,EMERSON, 5835 N TACOMA ST INDIANAPOLIS 46220	AN	134
DORMIRE,ROBT,DARRELL, 2200 LAKE AVE STE 150 FORT WAYNE 46805	R	082	DU BOIS,CHAS,CLIFFORD, MILLERS MERRY MANOR INC WARSAW 46580	OS	166
DOSS,JEROME,FAULKNER, 3415 S LAFOUNTAIN KOKOMO 46901	OBG	126	DU BOIS,MICHAEL,BRUCE, 3524 NORTH MERIDIAN ST INDIANAPOLIS 46208	IM	134

DU BOIS, RAMON, B, 519 CALVERT LANE LAFAYETTE 47905	GP	286	DUNHAM, HENRY, H, 1025 MANCHESTER WABASH 46992	R	302
DUBOIS, DON, RAMON, 7150 S MADISON ST INDIANAPOLIS 46227	PD	134	DUNKIN, RAMON, SINCLAIR, 3266 N MERIDIAN ST INDIANAPOLIS 46208	PUD	134
DUCANES, ARNOLD, DELLOTA, 215 N FRANKLIN ST GREENSBURG 47240	GP	054	DUNLAP, DAVID, L, 423 JMS BLDG SOUTH BEND 46624	IM	258
DUGAN, JOHN, RICKWOOD, 6332 N GUILFORD INDIANAPOLIS 46220	FP	134	DUNNING, PRESTON, M, 3210 WATLING ST EAST CHICAGO 46312	OM	174
DUGAN, THOS, PATRICK, 1950 DOCTORS PARK DR COLUMBUS 47201	GP	014	DUNSTONE, HARRY, CARTER, 105 THREE RIVERS EAST FORT WAYNE 46802	P	082
DUGAN, WM, MILLER, 3524 N MERIDIAN INDIANAPOLIS 46208	HEM	134	DUPLER, LEE, FORREST W, 1201 OAK ST FRANKFORT 46041	IM	042
DUKES, BETTY, J DICKERSON, S 3D ST DUGGER 47848	GP	282	DUQUE, FAUSTO, 328 MOCKINGBIRD HILL RD LOUISVILLE KY 40207	AN	034
DUKES, DAVID, J, 439 E CHESTNUT ST CORYDON 47112	GP	114	DURHAM, THOMAS, E, 2200 CALIFORNIA ROAD ELKHART 46514	OKS	070
DUKES, JOS, ELLSWORTH, S 3D ST DUGGER 47848	GP	282	DURKEE, MELVIN, S, 3700 BELLEMEADE AVE EVANSVILLE 47715	GS	296
DUKES, MICHAEL, JOS, 801 ST MARYS DR SUITE 400 EVANSVILLE 47715	OBG	296	DUSARD, JOS, CAVANAW, 304 CITIZENS NATL BANK BLDG BEDFORD 47421	GP	182
DUKES, RUSSELL, JAMES, 815 MEMORIAL PARKWAY ROCHESTER MN 55901	IM	282	DUTCHMAN, WM, RUPERT, 325 SOUTH CELIA AVE MUNCIE 47303	AN	062
DULIN, BASIL, BURTON, ST JOHNS HOSP ANDERSON 46011	R	186	DWYER, DANL, JOS, ROCKVILLE TOWN SQUARE ROCKVILLE 47872		218
DUMANIAN, ARA, VAHAN, 3680A 179TH ST HAMMOND 46323	CD	174	DY, JAMES, T, 2530 SAND ST PORTAGE 46368	GP	230
DUNCAN, JAMES, E, R R 1 BOX 294D LA FONTAINE 46940	PTH	302	DY, JULEY, TEMBRINA, 2642 ELEANOR ST PORTAGE 46368	GP	230
DUNCAN, RAYMOND, E, 2900 W 16TH ST BEDFORD 47421	GP	182	DYAR, EDWIN, WM, 2020 WEST 86TH STREET INDIANAPOLIS 46260	OPH	134
DUNCAN, STUART, JACKSON, 3037 S MERIDIAN ST INDIANAPOLIS 46217	GP	134	DYAR, ROBT, WM, 2020 W 86TH ST INDIANAPOLIS 46260	OPH	134
DUNCAN, WM, ARBAUGH, 204 MEADOW DR DANVILLE 46122	OBG	118	DYCUS, WALTER, ARRINGTON, 319 N ST JOSEPH AVE EVANSVILLE 47712	GP	296
DUNFEE, THOS, PATRICK, 912 E LA SALLE ST SOUTH BEND 46617	NEP	258	DYE, CLOYD, LEROY, 1007 N 16TH ST NEW CASTLE 47362	IM	122

YE,WM,EDWARD, PROFESSIONAL BLDG OAKLAND CITY 47560	GP	094	ECKERT,RUSSELL,ALOIS, TWO CHASE PARK LOGANSPOET 46947	R	030
YER,GEO,WALLACE, 2710 WILSON DR TERRE HAUTE 47807	GP	298	ECKERT,RUTH,LOUISE, 3217 LAKE AVE FORT WAYNE 46805	FP	082
YER,JOHN,KELLY, 2828 FAIRFIELD AVE FORT WAYNE 46807	NEP	082	EDMANDS,ROBT,EMERSON, 1213 NORTH ARLINGTON INDIANAPOLIS 46219	CD	134
YKEN,MARK,LEWIS, I U MEDICAL CENTER INDIANAPOLIS 46202	N	134	EDWARDS,BERNARD,ELMO, 3355 TWYCKENHAM DR SOUTH BEND 46614	AN	258
YKHUIZEN,THEODORE,A, 608 E WASHINGTON ST FRANKFORT 46041	U	042	EDWARDS,DAVID,JEAN, 1330 W MICH ST BRD OF HLTH INDIANAPOLIS 46206	PH	134
E YRL,MAX,MARKLEY, 502 S BERKLEY RD KOKOMO 46901	IM	126	EDWARDS,HENRY,GRADY, 518 S 7TH ST TERRE HAUTE 47807	U	298
YRP,EVANSON,BYERS, 3368 WASHINGTON BLVD INDIANAPOLIS 46205	PH	134	EDWARDS,JAMES,LARKIN, 900 I STREET LA PORTE 46350	PD	178
YASTER,JAMES,NEIL, 1912 BUNDY AVE NEW CASTLE 47362	GP	122	EDWARDS,JOHN,ROBT, 903 S CEDAR AUBURN 46706	GS	058
YATON,EDWIN,RAY, COMMUNITY HQSP INDIANAPOLIS 46219	EM	134	EDWARDS,JOSHUA,L, IND UNIV MED CTR DEPT-PATH INDIANAPOLIS 46202	PTH	134
YATON,LYMAN,DALE, 6921 N KEYSTONE AVE INDIANAPOLIS 46220	IM	134	EDWARDS,JUDITH,ANN JOHNS, 8836 KIRKHAM RD INDIANAPOLIS 46260	CHP	134
YATON,MARION,JOSHUA, 214 LIFE BLDG LAFAYETTE 47901	U	286	EDWARDS,THOMAS,A, 152 CREIGHTON ROAD WEST LAFAYETTE 47906	ORS	286
YBBINGHOUSE,TOM,H, 98 W MAIN ST RICHMOND 47374	GP	314	EDWARDS,WENDELL,LEE, 8836 KIRKHAM RD INDIANAPOLIS 46260	AN	134
YBERT,J,WAYNE, 1618 STOP 11 RD APT 7 INDIANAPOLIS 46227	GP	134	EDWARDS,WILLIAM,A, 1655 HAWTHORNE DR PLAINFIELD 46168	FP	118
YBERT,TERRY,WAYNE, 509 RIDGE RD MUNSTER 46321	D	174	EDWARDS,WM,FRANCIS, 604 E SPRING ST NEW ALBANY 47150	OTO	078
YBERTH,EDWARD,PALMER, 3266 NORTH MERIDIAN INDIANAPOLIS 46208	AN	134	EGAN,SHERMAN,L, 423 JMS BLDG SOUTH BEND 46601	IM	258
YCHEVERRIA,R,E, 2200 CALIFORNIA ROAD ELKHART 46514	URS	070	EGBERT,HERBERT,L, 5317 E 16TH ST INDIANAPOLIS 46218	GS	134
YCHSNER,HERMAN,J, DOCTORS PARK DR COLUMBUS 47201	AN	014	EGGER,ROSS,L, RTE 1 BOX 75 DALEVILLE 47334	FP	062
YCHT,CHAS,ROBT, 3266 N MERIDIAN APT 404 INDIANAPOLIS 46208	OBG	134	EGGERS,HENRY,WM, 110 RIDGE RD MUNSTER 46321	OBG	174

EGGERS,RICHARD,ROY, 120 W PIKE ST CRAWFORDSVILLE 47933	GP	198	ELLIS,GEO,MELVIN, 108 E 10TH ST CONNERSVILLE 47331	FP	07
EGNATZ,CHAS,DYKE, U S 41 AND 3C SCHERERVILLE 46375	GP	174	ELLIS,LYMAN,HALL, 408 E 3RD ST LIZTON 46149	GP	11
EGNATZ,NICHOLAS, 30 DOUGLAS AVE HAMMOND 46320	GP	174	ELLIS,ROBT,KEITH, 2200 CALIFORNIA RD ELKHART 46514	ORS	070
EICHER,PALMER,O, 4401 WASHINGTON BLVD INDIANAPOLIS 46205	ORS	134	ELLIS,WM,NICOL, 1640 N RITTER INDIANAPOLIS 46218	FP	134
EILER,PAUL,AUSTIN, 1104 N WAYNE ST NORTH MANCHESTER 46962	GP	302	ELSHOFF,DONALD,VIRGIL, 3700 BELLEMEADE AVE STE 104 EVANSVILLE 47715	IM	296
EISAMAN,JACK,LANGOHR, 1422 HUNTER ROAD BLUFFTON 46714	CD	318	ELSHOUT,CLEMENT,H, 409 FIRST NATL BK LA PORTE 46350	AN	178
EL-ISSA,SA'D,ISSA, 3050 POPLAR ST TERRE HAUTE 47803	CD	298	ELSTEN,AUBREY,W, 5000 GULF BLVD ST PETERSBURG FL 33706	GP	186
ELDRIDGE,GAIL,EDWARD, 5239 NOB LANE INDIANAPOLIS 46226	GP	134	ELSTON,LYNN,WICKWIRE, 7716 S HANNA ST FORT WAYNE 46806	GS	082
ELKINS,JAMES,PAUL, 2045 LICK CREEK INDIANAPOLIS 46203	OBG	134	ELSTON,RALPH,WICKWIRE, 2305 RANDALL RD FORT WAYNE 46804	GS	082
ELLEMAN,JOHN,HENRY, 800 SOUTH BERKLEY KOKOMO 46901	FP	126	ELWARD,CARL,J, 1025 MANCHESTER WABASH 46992	R	302
ELLER,ALVAN,LA VERNE, 115 N CENTER ST FLORA 46929	GP	026	ELY,CECIL,W, 3305 ALLISON WAY LOUISVILLE KY 40220	R	034
ELLETT,JOHN, BOX 126 COATESVILLE 46121	GP	242	EMERY,CHARLES,B, 711 W 2ND BLOOMINGTON 47401	ORS	214
ELLIOTT,DANL,ROBT, 7610 CANDLEWOOD LANE INDIANAPOLIS 46250	R	134	EMERY,CHAS,BARTLETT, 2325 Q ST BEDFORD 47421	GP	182
ELLIOTT,PAUL,W, 332 PARK LANE LAFAYETTE 47906	PTH	286	EMHARDT,JOHN,THILO, 3305 BRILL RD INDIANAPOLIS 46227	OM	134
ELLIOTT,THOS,A, ELKHART CLINIC BOX 2507 ELKHART 46514	IM	070	EMKES,BERNARD,JOHN, 6201 PARK AVE INDIANAPOLIS 46220	GP	134
ELLIOTT,WM,CROMARTIE, 3524 N MERIDIAN ST INDIANAPOLIS 46208	CD	134	ENDERLE,FRANK,JOHN, 1700 N 7TH ST TERRE HAUTE 47807	GS	298
ELLIS,CHAS,ROBT, BLOOMINGTON HOSP DEPT PTH BLOOMINGTON 47401	PTH	214	ENDICOTT,WAYNE,H, 120 W MC KENZIE RD GREENFIELD 46140	FP	110
ELLIS,FORREST,D, IND UNIV SCHOOL OF MEDICINE 1100 WEST MICHIGAN ST INDIANAPOLIS 46202	OPH	134	ENGEL,EDGAR,L, 326 S E 7TH ST EVANSVILLE 47713	OBG	296

ENGEL, HOWARD, ROBT, 919 E JEFFERSON ST SOUTH BEND 46622	IM	258	ESTACIO, ROMEO, Y, 9142 CHESTNUT LANE MUNSTER 46321	GP	174
ENGLISH, HUBERT, MORTON, 521 WEST 39TH PLACE HOBART 46342	GP	174	EVANS, DANL, RICHARD, 2005 VALPARISO ST VALPARAISO 46383	OPH	230
ENGLISH, JOHN, PAUL, 211 N EDDY SOUTH BEND 46617	IM	258	EVANS, DAVID, LESLIE, 2424 FERRY ST LAFAYETTE 47904	P	286
ENSEY, PHILIP, L, 29 LONGRIDGE RD TERRE HAUTE 47802	GP	298	EVANS, FREDERICK, H, 2140 N CAPITOL AVE INDIANAPOLIS 46202	OTO	134
ENTNER, CHAS, LEROY, 226 S MERIDIAN DUNKIRK 47336	GP	146	EVANS, FREDERICK, J, 226 SO MAIN ST CLINTON 47842	GP	218
EPPS, JAMES, HARMAN, 2330 BEACON ST FORT WAYNE 46805	AN	082	EVANS, O, THOMAS, 611 HARRIET ST STE 401 EVANSVILLE 47710	OKS	296
ERDEL, MILTON, WM, 2 E WHITE ST FRANKFORT 46041	OTO	042	EVANS, PAUL, VINCENT, METHODIST HOSP INDIANAPOLIS 46202	PTH	134
EREHART, MARK, GEO, MAPLE GROVE RD HUNTINGTON 46750	OPH	130	EVENS, MARVIN, AMOS, 5350 E 38TH INDIANAPOLIS 46218	AN	134
ERICKSON, GUSTAF, W, 211 N EDDY AT COLFAX SOUTH BEND 46617	PD	258	EVERLY, RALPH, VERNON, 706 E 46TH INDIANAPOLIS 46205	GP	134
ERICSON, HAROLD, L, BOX 366 WINDFALL 46076	GP	290	EVISTON, JOHN, BOYD, 34 E WASHINGTON ST HUNTINGTON 46750	GP	130
ERICSON, HOMER, STANLEY, 107 S DIXON RD KOKOMO 46901	GP	126	EWER, ROBT, WAYNE, 1112A SOUTH VILLA DRIVE EVANSVILLE 47714	IM	296
ERTAN, BEHIC, M, 7905 CALUMET AVE MUNSTER 46321	IM	174	FADUL, ARMAND, F 47 W 68TH PL MERRILLVILLE 46410	IM	174
ERWIN, WINFORD, ROBT, 900 I ST LA PORTE 46350	GP	178	FAILEY, ROBT, B, I U MEDICAL CENTER INDIANAPOLIS 46202	IM	134
ERXLEBEN, WALTER, OSCAR, 303 S MAIN ST BLUFFTON 46714	IM	318	FARAHMAND, FIROUZ, 2674-P PORTAGE MALL PORTAGE 46368	PD	230
ESKEW, KENNETH, W, SCOTT MEDICAL BLDG SULLIVAN 47882	GP	282	FARID, RAHIM, BOX 108 BRAZIL 47834	GS	036
ESKEW, PHILIP, NEWTON, 614 S RANGE LINE RD CARMEL 46032	OBG	134	FARINAS, CIRILO, T, 25 DOUGLAS HAMMOND 46320	PTH	174
ESPINO, JOSE, CANCIO, 7550 HOHMAN MUNSTER 46321	GS	174	FARIS, JAMES, VANNOY, KRANNERT INST OF CARDIOLOGY 1001 WEST 10TH STREET INDIANAPOLIS 46202	CD	134
ESPY, THEODORE, R, 1901 BROADWAY GARY 46407	GP	174	FARMER, CHAS, ROBT, 619 WEST FIRST STREET BLOOMINGTON 47401	GP	214

FARNER, JAMES, E, 130 W PARK LANE SOUTH BEND 46601	GE	258	FELDNER, RONALD, PETER, 110 RIDGE RD MUNSTER 46321	GP	174
FARR, JAMES, CURRY, 401 EAST 4TH ST BLOOMINGTON 47401	IM	214	FELGER, THOS, ALLEN, 5717 S ANTHONY BLVD FORT WAYNE 46806	FP	082
FARRELL, JOHN, JOS, 120 W MC KENZIE GREENFIELD 46140	AN	110	FELICIANO, ADORACION, 916 SOUTH 5TH ST TERRE HAUTE 47807	GP	298
FARRIS, JOHN, JOS, ST VINCENT HOSPITAL INDIANAPOLIS 46208	EM	134	FELICIANO, MACARIO, G, 916 S 5TH ST TERRE HAUTE 47807	AN	298
FAULKNER, BARBARA, ELLEN, 321 W 20TH ST CONNERSVILLE 47331	IM	074	FENNEMAN, ROBT, J, 402 S E 7TH ST EVANSVILLE 47713	OPH	296
FAULKNER, DONALD, JOS, 7905 CALUMET MUNSTER 46321	FP	174	FENSTERMACHER, ROBT, EDWIN, 506 MICHIGAN ST WALKERTON 46574	FP	258
FAUSSET, C, BASIL, 1815 N CAPITOL AVE INDIANAPOLIS 46202	NS	134	FERGUSON, ARTHUR, N, 1935 GOLDEN RAIN RD WALNUT CREEK CA 94595	CD	082
FAUST, HOWARD, MACY, 1508 N MADISON ANDERSON 46012	GP	186	FERGUSON, JAMES, F, PO BOX 1149 BLOOMINGTON 47401	DR	214
FAUSTINO, CARLOS, DAET, 710 JEFFRAS AVE MARION 46952	AN	098	FERGUSON, JEFFREY, HALE, 3250 ARBUTUS DR INDIANAPOLIS 46224	FP	134
FAW, MELVIN, L, 421 CHESTNUT ST EVANSVILLE 47713	CD	296	FERGUSON, PHILIP, CHAS, 1025 MANCHESTER AVE WABASH 46992	FP	302
FEAR, OLAN, DE WITT, BOX 2507 ELKHART 46514	IM	070	FERGUSON, STEPHEN, C, 314 S E RIVERSIDE DR EVANSVILLE 47713	MNS	296
FECHTMAN, WM, FREDERICK, 1815 N CAPITOL AVE INDIANAPOLIS 46202	OTO	134	FERGUSON, WILLIAM, B, 2525 SOUTH ST LAFAYETTE 47904	ORS	286
FEDOR, THOS, ANTHONY, 1525 WINDING WAY ANDERSON 46011	P	186	FERRARA, DONALD, WM, 18 W 5TH ST PERU 46970	GS	194
FEENEY, MARTIN, THOMAS, 4094 ROCKINGCHAIR RD GREENWOOD 46142	OBG	134	FERRARA, JOS, FRANCIS, 111 S WATER ST P O BOX 6 FRANKLIN 46131	GS	158
FEFERMAN, MARTIN, E, 919 E JEFFERSON BLVD SOUTH BEND 46622	NS	258	FERRARA, SAML, J, 18 W 5TH ST PERU 46970	GS	194
FEINN, HARRY, S, 1013 INDIANA AVE LA PORTE 46350	OTO	178	FERRARA, THOS, ALBERT, MEDICAL ARTS BLDG NORTH 5508 EAST 16TH ST NO 25 INDIANAPOLIS 46218	OBG	134
FELDMAN, HOWARD, EUGENE, 7905 CALUMET MUNSTER 46321	OM	174	FERREE, H, LANE, 1815 NORTH CAPITOL AVE NO 202 INDIANAPOLIS 46202	P	134
FELDMAN, MAX, 1921 MIAMI ST SOUTH BEND 46613	GP	258	FERREE, MARY, M, 1815 NORTH CAPITOL AVE NO 202 INDIANAPOLIS 46202	CHP	134

FERRELL,MARS,BENTON, 122 NORTH MAIN ST FORTVILLE 46040	FP	186	FIRESTEIN,BEN,Z, 919 E JEFFERSON BLVD SOUTH BEND 46622	C	258
FERRY,FRANCIS,A, 1638 E RAYMOND INDIANAPOLIS 46203	UBG	134	FIRESTEIN,RAY, 502 N IRONWOOD DR SOUTH BEND 46615	IM	258
FERRY,JOHN,LUMICE, 2450-169TH ST HAMMOND 46323	IM	174	FISCHER,A,ALAN, DEPT OF FAMILY MEDICINE 1100 WEST MICHIGAN ST INDIANAPOLIS 46202	FP	134
FESSLER,GORDON,SOISTER, 226 MAIN ST RISING SUN 47040	GP	050	FISCHER,BURNELL, 49 INDI-ILLI PKWY HAMMOND 46324	AN	174
FETROW,KENNETH,O, 852 STATE LINE CALUMET CITY IL 60409	ORS	174	FISCHER,CHAS,KENNETH, 801 ST MARYS DRIVE SUITE 504 EVANSVILLE 47715	OPH	296
FEUER,HENRY, 601 WEST 91ST STREET INDIANAPOLIS 46260	NS	134	FISCHER,WARREN,E, ST JOHNS HOSP ANDERSON 46011	R	186
FIACABLE,JOS,PAUL, 347 W BERRY ST FORT WAYNE 46802	P	082	FISCUS,CLIFFORD,WM, R R NO 2 BOX 84B ZIONSVILLE 46077	OPH	134
FIEDOR,JOHN,P, 1250 CHESTER BLVD RICHMOND 47374	ORS	314	FISH,CLYDE,MONROE, DOUGLAS MI 49406	CRS	258
FIELD,THOS,EMERY, 3824 JOAN AVE EVANSVILLE 47711	FP	296	FISH,EDSON,CLEMENT, 19054 SUMMERS DR SOUTH BEND 46637	AN	258
FIELDS,DON,C, 2600 GREENBUSH ST LAFAYETTE 47902	GS	286	FISHER,HENRY, 1502 S WASHINGTON ST MARION 46952	FP	098
FIELDS,DONALD,LEE, 3804 SOUTHLAND AVE KOKOMO 46901	PD	126	FISHER,JOHN,EDWARD, 540 S MAINT ST NEW CASTLE 47362	IM	122
FIELDS,MAX,L, 1307 U S 24 WEST MONTICELLO 47960	GP	322	FISHER,PIERRE,JAMES, 500 WABASH AVE MARION 46952	GS	098
FILIPEK,WALTER,JOS, 311 ODD FELLOW BLDG SOUTH BEND 46601	GP	258	FISHER,THOS,FORREST, 215 BROADWAY GARY 46402	OM	174
FILMER,ELEANOR,H M JULIN, 801 ELM DRIVE WEST LAFAYETTE 47906	GP	286	FISHER,WALTER,SCOTT, 3450 NUGENT BLVD COLUMBUS 47201	CD	014
FINFROCK,JAMES,D, 515 S 2ND ST ELKHART 46514	GS	070	FISHER,WM,PAUL, I U MEDICAL CENTER INDIANAPOLIS 46202	P	134
FINK,JAMES,MAURICE, 912 EAST LASALLE AVE SOUTH BEND 46617	IM	258	FITZGERALD,EDWARD,BRICE, 8402 HARCOURT STE 411 INDIANAPOLIS 46260	CDS	134
FINNERAN,JOS,CHAS, 8402 HARCOURT RD APT 417 INDIANAPOLIS 46260	GS	134	FITZGERALD,WM,JOS, 1118 E ST CLAIR ST INDIANAPOLIS 46202	GP	134
FIPP,AUGUST,LORENZ, 5518-6 OLD DOVER BLVD FORT WAYNE 46815	GP	206	FITZKEE,WM,ELWOOD, 120 W MAIN ST ALBION 46701	FP	206

FITZPATRICK, HARRY, W, 1309 S ANDERSON ST ELWOOD 46036	GP	186	FONG, THEODORE, C C, 316 BELLAIRE DR MADISON 47250	P	150
FITZPATRICK, JAMES, S, 603 W ARCH ST PORTLAND 47371	GS	146	FORCHETTI, JOHN, ANTHONY, 1610 COBBLESTONE CT CHESTERTON 46304	CD	230
FITZPATRICK, WM, J, 110 RIDGE RD MUNSTER 46321	GS	174	FORREST, OTTO, NORMAN, 912 E LA SALLE ST SOUTH BEND 46617	OBG	258
FITZSIMMONS, SAM, LEE, 900 SOUTH BOEKE RD EVANSVILLE 47714	U	296	FORSEE, NORMAN, EDWARD, 506 EAST CHARLESTOWN AVE JEFFERSONVILLE 47130	GP	034
FLACK, RUSSELL, ALLEN, 432 CURSON AVE LOS ANGELES CA 90036	IM	286	FORTNER, RAY, EDWARD, DOCTORS PARK BLDG 1 COLUMBUS 47201	U	014
FLAHERTY, ROBT, ANTHONY, 2828 FAIRFIELD AVE FORT WAYNE 46807	R	082	FORTNER, WM, ROBT, 3032 BROOKEHAVEN ROAD NEW ALBANY 47150	R	078
FLANAGAN, PAUL, M, 5842 N LA SALLE INDIANAPOLIS 46220	OS	134	FOSBRINK, EPHRAIM, L, 218 S HUNTINGTON SYRACUSE 46567	GP	070
FLANDERS, ROBT, 3266 N MERIDIAN ST INDIANAPOLIS 46208	IM	134	FOSGATE, HAROLD, L, 4301 E 38TH ST INDIANAPOLIS 46218	GP	134
FLANIGAN, M, B, 3305 RUTLEDGE DR INDIANAPOLIS 46208	AN	134	FOSTER, JOHN, ARTHUR, P O BOX 268 FORT WAYNE 46801	PTH	286
FLANNIGAN, HARLEY, F, MED BLDG LAGRANGE 46761	GP	170	FOSTER, LEE, N, RR 3 2020 136TH ST W CARMEL 46032	CLP	134
FLEISCHL, HERBERT, P O BOX 192 SANIBEL FL 33957	P	134	FOSTER, LOWELL, GEO, 3500 LAFAYETTE RD INDIANAPOLIS 46222	P	134
FLORA, JOS, O, 5604 ROCKVILLE RD INDIANAPOLIS 46224	GP	134	FOSTER, RAY, D, 8330 NORTH NAAB ROAD SUITE 203 INDIANAPOLIS 46260	OTO	134
FLORCRUZ, ARTURO, ROXAS, 2805 HIGHWAY AVE HIGHLAND 46322	GS	174	FOSTER, RAY, T, 420 N MAIN ST NEW CASTLE 47362	OM	122
FLOYD, MALCOLM, STAFFORD, GOOD SAMARITAN HOSP VINCENNES 47591	R	162	FOUNTAIN, THOS, JAY, 1618 24TH ST BEDFORD 47421	GP	182
FOLEY, HANSEL, ODELL, 701 NORTH ST JOSEPH ST SOUTH BEND 46601	GP	258	FOWLER, RICHARD, ROSS, 104 N GRANT ST BLOOMINGTON 47401	GP	214
FOLEY, PATRICK, L, 3500 LAFAYETTE ROAD INDIANAPOLIS 46222	FP	134	FOX, JACK, MILLER, 7550 MOHMAN AVE MUNSTER 46321	D	174
FOLLIS, CLIFTON, G, G-6499 FLUSHING RD FLUSHING MI 48433	TR	296	FOX, RICHARD, FREDERICK, 2828 FAIRFIELD AVE FORT WAYNE 46807	TR	082
FOLTZ, JACK, LLOYD, 913 S GRANT AVE CRAWFORDSVILLE 47933	OBG	198	FOY, THOS, DANL, FOY FAMILY PRACTICE INC 6642 ST JOE RD FORT WAYNE 46808	FP	082

FRABLE, FRANK, L, 370 BIELBY RD LAWRENCEBURG 47025	GS	050	FRENCH, RICHARD, STEPHENS, 8402 HARCOURT RD INDIANAPOLIS 46260	N	134
FRAHM, CHAS, JOS, 1820 E COLUMBUS DR EAST CHICAGO IN 46312	CD	174	FRETZ, RICHARD, CARL, 2608 W SYCAMORE KOKOMO 46901	FP	126
FRANCE, LLOYD, CAROL, 1223 N CENTER ST PLYMOUTH 46563	GS	190	FREY, HARLEY, H, 405 LAFAYETTE LIFE BLDG LAFAYETTE 47901	AN	286
FRANCO, JAMES, MICHAEL, 611 HARRIET ST NO 301 EVANSVILLE 47710	NS	296	FRIEDMAN, ISADORE, E, 7217 INDIANAPOLIS BLVD HAMMOND 46324	OPH	174
FRANK, HERBERT, 919 E JEFFERSON BLVD SOUTH BEND 46622	IM	258	FRIEDMAN, MORRIS, S, 919 E JEFFERSON BLVD SOUTH BEND 46622	ORS	258
FRANK, JOHN, RAY, 23 LINCOLNWAY VALPARAISO 46383	UPH	230	FRIESEN, GENE, WELDON, 103 BROWN MIDDLEBURY 46540	ID	070
FRANKEL, GERALD, JOS, 9018 BUCKEYE COURT INDIANAPOLIS 46260	U	134	FRIESKE, DAVID, ALLEN, 7905 CALUMET AVE MUNSTER 46321	P	174
FRANKEN, EDMUND, A, INDIANA UNIV MED CTR INDIANAPOLIS 46202	PDR	134	FRITCH, JOHN, MARTIN, 710 S 21ST ST LAFAYETTE 47905	OPH	286
FRANKHOUSER, CHAS, M A, PO BOX 268 FORT WAYNE 46801	PTH	082	FRITH, LOUIS, GORDON, 51757 N HICKORY RD GRANGER 46530	GP	258
FRANKLIN, JOS, EDWARD, 421 CHESTNUT ST EVANSVILLE 47713	OBG	296	FRITZ, WALTER, 1520 SOUTH HEATON ST KNOX 46534	FP	274
FRANKLIN, WILLIAM, L, 33 E 37TH ST INDIANAPOLIS 46205	ORS	134	FROMHOLD, WILLIS, A, 510 WILLARD AVE INDIANAPOLIS 46227	IM	134
FRANKOWSKI, CLEMENTINE, E, 1706 LA PORTE AVE WHITING 46394	PH	174	FROST, ROBT, JOS, 1701 BUFFALO ST P O BOX 341 MICHIGAN CITY 46360	PTH	178
FRANZ, SHERMAN, GAYLE, 2510 SANDCREST BLVD COLUMBUS 47201	P	014	FRY, ROBT, DE VAULT, 1240 CONSOLIDATED BLDG INDIANAPOLIS 46204	GS	134
FRASH, DE, VON WALTERS, 1910 MIAMI ST SOUTH BEND 46613	GP	258	FUELLING, JAMES, LOUIS, 217 E GRANT ST MARION 46952	OPH	098
FREDERICK, JOS, A, 1201 MICHIGAN AVENUE LOGANSPORT 46947	IM	030	FUGELSO, ERLING, SVERRE, 207 HERITAGE RD BLOOMINGTON 47401	IM	214
FREDERICK, TERRY, LEE, 622 S RANGE LINE ROAD CARMEL 46032	FP	134	FULLER, ROBT, GLEN, DOCTOR'S PARK BLDG 2 COLUMBUS 47201	FP	014
FREED, JOHN, ELIAS, 1024 S 6TH ST TERRE HAUTE 47807	GS	298	FULTON, WM, HALL, 7216 S MADISON INDIANAPOLIS 46227	N	134
FREEMAN, MAX, E, 89 1ST AVE SW CARMEL 46032	GP	134	FULTZ, ROY, LEE, 55 SYCAMORE ROAD JEFFERSONVILLE 47130	AN	034

FURMAN,ROBT,H, 307 E MC CARTY ST INDIANAPOLIS 46225	OS	134	GALUP,LUIS,NEMESIO, 531 N MAIN ST SOUTH BEND 46601	PTH	258
FURR,JACK,DEAN, PARK AVE HILLSBORO 47949	GP	086	GAMBILL,WM,DUDLEY, 118 W 18TH ST INDIANAPOLIS 46202	IM	134
FURTADO,ROBT, 2828 FAIRFIELD AVE FORT WAYNE 46807	PS	082	GAMMELL,LINDLEY,LLOYD, 2756 25TH ST COLUMBUS 47201	AN	014
FUTTERKNECHT,JAMES,OTTO, ELKHART CLINIC BOX 2507 ELKHART 46514	GS	070	GANJI,NASSER, 403 EAST FOURTH STREET BLOOMINGTON 47401	AN	214
G					
GABATO,MANUEL,BARDOS, 12110 GRANT ST CROWN POINT 46307	IM	174	GANNON,ANTHONY,PATRICK, 100 WEST MADISON ST FRANKLIN 46131	FP	158
GABOVITCH,EDWARD,ROBT, 1935 N CAPITOL INDIANAPOLIS 46202	RHU	134	GANSER,RALPH,VINCENT, 810 E COLFAX SOUTH BEND 46617	OTO	258
GABOYA,RUBEN,READ, P O BOX 577 BUNKER HILL 46914	IM	126	GANSER,RICHARD,A, 1020 WILSON BLVD MISHAWAKA 46544	EM	258
GABRIEL,MAGDI, 320 WEST 4TH ST MISHAWAKA 46544	ORS	258	GANZ,MAX, 1251 KEM RD STE A MARION 46952	GP	098
GABRIELSEN,TED,HOWARD, 120 WEST MCKENZIE ROAD GREENFIELD 46140	GS	134	GARBER,J,NEILL, 7036 N PENNSYLVANIA ST INDIANAPOLIS 46220	ORS	134
GADDY,NELSON,DON, 3500 LAFAYETTE ROAD INDIANAPOLIS 46222	GP	134	GARCEAU,GEORGE,J, 1164 IVY LANE INDIANAPOLIS 46220	ORS	134
GAHIMER,JOE,EDWARD, 215 W 19TH ST ANDERSON 46014	IM	186	GARCIA,MANUEL,GENETA, P O BOX 120 BATESVILLE 47006	GS	250
GALANTE,ALBERT, 800 MAC ARTHUR BLVD MUNSTER 46321	UBG	174	GARCIA,TIERRY,F, 1500 ALBANY ST BEECH GROVE 46107	OTO	134
GALANTE,GLORIA, 625 RIDGE ROAD MUNSTER 46321	P	174	GARD,DANL,A, 1919 N CAPITOL ST INDIANAPOLIS 46202	OM	134
GALINIS,ALGIMANTAS,JOS, 1225 E COOLSPRING MICHIGAN CITY 46360	GP	178	GARDINER,SPRAGUE,HEMAN, 1100 W MICHIGAN ST INDIANAPOLIS 46202	OBG	134
GALLAGHER,DANL,F, 5219 SOUTH WAYNE AVE FORT WAYNE 46807	AN	082	GARDNER,AUSTIN,L, 8402 N HARCOURT RD INDIANAPOLIS 46260	CDS	134
GALLANOSA,ARTURO,G, 2116 HEATHER ROAD ANDERSON 46012	AN	186	GARDNER,FREDERIC,B, 530 WILLOW SPRING RD INDIANAPOLIS 46240	AN	134
GALLIHER,MARJORIE,JANE, 410 WHITE RIVER BLVD MUNCIE 47303	GP	062	GARDNER,IAN,ROSS, 919 EAST JEFFERSON BLVD SOUTH BEND 46622	CDS	258
GALLINATTI,JOHN,JOS, 2177 GREEN VALLEY DR LOFS CROWN POINT 46307	GP	230	GARDNER,MELVIN,DUANE, 801 WASHINGTON ST MICHIGAN CITY 46360	ABS	178

GARDNER,NORMAN,DAVID, 4925 BUTTWOOD CRESCENT INDIANAPOLIS 46208	R	134	GATTMAN,G,BEACH, ELKHART CLINIC BOX 2507 ELKHART 46514	PD	070
GARDNER,RUSSELL,ALLEN, 801 WASHINGTON ST MICHIGAN CITY 46360	OBG	178	GATZIMOS,CHRISTOS,D, DUKES HOSPITAL PERU 46970	PTH	194
GARFIELD,MARTIN,D, 3705 N COLLEGE AVE INDIANAPOLIS 46205	GP	134	GAUL,L,EDWARD, 509 HULMAN BLDG EVANSVILLE 47708	D	296
GARGETT,JAMES,MICHAEL, 706 RIVER RD MARION 46952	FP	098	GAUNT,EVERETT,WELKER, 214 E JOHN ST ALEXANDRIA 46001	GP	186
GARNER,WM,HOWARD, 919 E SPRING ST NEW ALBANY 47150	GS	078	GAURANO,LAURO,M, 234 E SOUTHERN INDIANAPOLIS 46225	IM	134
GARNER,WM,HOWARD, 919 E SPRING ST NEW ALBANY 47150	GS	078	GEBELE,GENE,P, LABORATORY DECATUR CO HOSP GREENSBURG 47240	PTH	054
GARNER,WM,STANLEY, 2704 E 62ND ST INDIANAPOLIS 46220	GP	134	GECKLER,CHAS,ELMER, 1007 W NORTH ST MUNCIE 47303	PTH	062
GARRETT,ROBT,AUSTIN, I U MEDICAL CTR INDIANAPOLIS 46202	U	134	GEHRING,THOS,ALBERT, 6111 HARRISON ST MERRILLVILLE 46410	GP	174
GARRISON,JAMES,L, 11890 WELLAND ST CUMBERLAND 46229	GP	110	GEICK,RAYMOND,GODFREY, 109 N MC CREARY ST FORT BRANCH IN 47648	GP	094
GARRISON,LEON,JOHN, 515 E MAIN ST GAS CITY 46933	GP	098	GEIDER,ROY,AUGUST, 5816 PLEASANT RUN INDIANAPOLIS 46219	GP	134
GARTNER,JOSE,C, MEMORIAL HOSPITAL JASPER 47546	AN	066	GEIGER,DILLON,D, 115 S LINCOLN ST BLOOMINGTON 47401	OTO	214
GARTON,HARRY,WASSON, 2528 EAST MCKELLIPS MESA AZ 85203		082	GEISLER,HANS,EMANUEL, 5470 E 16TH ST INDIANAPOLIS 46218	OBG	134
GARVISH,JOHN,FRANKLIN, 306 BINFORD ST CULVER HOSPITAL CRAWFORDSVILLE 47933	R	198	GELLER,SAML, R R 8 BOX 143-A EVANSVILLE 47711	GP	296
GASTINEAU,DAVID,C, 2200 LAKE AVE STE 150 FORT WAYNE 46805	TR	082	GENNA,MARY,MILLER, 1448 CRESTLINE DR SANTA BARBARA CA 93105	OS	134
GATES,GEO,E, 211 NORTH EDDY AT COLFAX SOUTH BEND 46617	IM	258	GEORGE,CHAS,LESTER, 1121 E 80TH ST INDIANAPOLIS 46240	AN	134
GATES,GEO,GREGORY, 814 LA PORTE VALPARAISO 46383	PTH	230	GEORGE,JOHN,LAWRENCE, 8330 NAAB ROAD INDIANAPOLIS 46260	GS	134
GATMAITAN,ALEJANDRO,V, 235 E CAREY KNIGHTSTOWN 46148	GP	122	GERDING,WM,JOHN, 5110 N CLINTON ST FORT WAYNE 46825	GP	082
			GERGESHA,EDWARD,ALEX, 211 N EDDY ST SOUTH BEND 46617	PD	258

GERIG, ELDON, LAVERN, 303 S MAIN ST MISHAWAKA 46544	GS	258	GILLESPIE, JACOB, EARL, 1246 CONSOLIDATED BLDG INDIANAPOLIS 46204	GP	134
GERRISH, DONALD, AIKMAN, 5206 CLINTON RD TERRE HAUTE 47805	GP	298	GILLILAND, JOHN, EDWARD, R R 3 BOX 206 G FRANKLIN 46131	OBG	158
GERTH, ROBT, EDWARD, METHODIST HOSP DEPT RADIOLOG INDIANAPOLIS 46202	R	134	GILLIM, PARVIN, DOUGLAS, 8402 HARCOURT RD INDIANAPOLIS 46260	OPH	134
GETTY, WM, HAYES, 421 CHESTNUT ST EVANSVILLE 47713	IM	296	GILLUM, EUGENE, MORIN, 522 W ARCH ST PORTLAND 47371	FP	146
GEVIRTZ, MILTON, BERNARD, 10141 E BAY HARBOR DR MIAMI BEACH FL 33154	GS	174	GILMAN, MARCUS, MANDLE, 2841 NE N MIAMI BEACH BLVD N MIAMI BEACH FL 33161	OS	258
			GILMORE, ROBT, WM, 1715 BUFFALO ST MICHIGAN CITY 46360	PD	178
GIBSON, ALOIS, E, 1250 CHESTER BLVD RICHMOND 47374	OKS	314	GILMORE, RUSSELL, ADAMS, 1715 BUFFALO ST MICHIGAN CITY 46360	GP	178
GIBSON, GRETA, MAXINE, 5744 BROADWAY TERR INDIANAPOLIS 46220	OS	134	GINGERICK, CHAS, MARVIN, BOX 208 LIBERTY CENTER 46766	GP	318
GIBSON, MILTON, EUGENE, 919 E JEFFERSON BLVD SOUTH BEND 46622	CD	258	GINSHERMAN, ABRAHAM, B, 1827 STATE ST NEW ALBANY 47150	GP	078
GICK, HERMAN, HENRY, 451 EASTERN AVE INDIANAPOLIS 46201	GP	134	GIORGIO, DOUGLAS, JOS, 916 S BURKHARDT RD EVANSVILLE 47715	AN	296
GIESTING, JEROME, RICHARD, 8112 QUINCY COURT FORT WAYNE 46815		082	GIRAGOS, HENRY, G, 800 MAC ARTHUR BLVD NO 12 MUNSTER 46321	TS	174
GIFFIN, CHAS, SALEN, 102 MED CTR FORT WAYNE 46802	OTO	082	GIRGIS, MEDHAT, HELMY, 2900 WEST 16TH ST BEDFORD 47421	IM	182
GILBERT, ALAN, RUSS, 2200 LAKE AVE NO 150 BLDG FORT WAYNE 46805	D	082	GIROD, ARTHUR, HENRY, RR 6 DECATUR 46733	GP	010
GILBERT, ROBT, G, 15 CLIFTON HEIGHTS CANNELTON 47520	DR	222	GIROD, DONALD, ALFRED, MED CENTER INDIANAPOLIS 46202	PDC	134
GILKISON, WM, MINOR, 8242 S MADISON INDIANAPOLIS 46227	FP	134	GISH, HOWARD, M, RR 2 DELPHI 46923	OS	286
GILL, HARBANS, SINGH, 605 WILSON CREEK ROAD LAWRENCEBURG 47025	IM	050	GIVEN, GILBERT, Z, 201 FRANCISCAN ROAD CROWN POINT 46307	PD	174
GILLESPIE, CHAS, F, 3266 N MERIDAN STE 302 INDIANAPOLIS 46208	OBG	134	GIZE, RAYMOND, WALTER, 2200 LAKE AVE SUITE 150 FORT WAYNE 46805	DR	082
GILLESPIE, GARLAND, RAY, 210 N MAIN ST BROWNSTOWN 47220	GP	138	GLACKMAN, JOHN, CLAY, MED CENTER BLDG ROCKPORT 47635	GP	270

GLENDENING, RICHARD, L, 8 CHASE PARK LOGANSPOET 46947	GF	030	GOLDENBERG, MITCHELL, E, 7550 MOHMAN AVE MUNSTER 46321	PS	174
GLOCK, DOUGLAS, E, 704 RIVER DRIVE MARION 46952	OKS	098	GOLDING, ROBT, FISCHER, P O BOX 8246 MERRILLVILLE 46410	AN	174
GLOCK, HUGH, EDWIN, 239 HILLSDALE GREENCASTLE 46135	GS	242	GOLDSTONE, ADOLPH, 3229 BROADWAY GARY 46409	GP	174
GLOCK, MAURICE, E, 1502 HAWTHORNE ROAD FORT WAYNE 46804	IM	082	GOLDSTONE, JOS, 10777 W SAMPLE RD CORAL SPRINGS FL 33065	GP	174
GLOCK, STEVEN, R, 5050 CLINTON ST FORT WAYNE 46825	ORS	082	GOLDSTONE, SIDNEY, RICHARD, 535 W 35TH AVE GARY 46408	FP	174
GLOVER, JOHN, LEE, 6160 SUNSET LANE INDIANAPOLIS 46208	GS	134	GOLDYN, RICHARD, ALAN, 303 METHODIST BLDG SHELBYVILLE 46176	OKS	266
GLOVER, WM, J, 6111 HARRISON ST MERRILLVILLE IN 46410	GS	174	GOLPER, MARVIN, NORMAN, 1907 W SYCAMORE ST KOKOMO 46901	R	126
GLUCKIN, JAMES, ELLIS, 805 WEST MARION ELKHART 46514	OPH	070	GOMEZ, CESAR, MORALES, 9429 NORTH COTE AVE MUNSTER 46321	GP	174
GODERSKY, GEO, EDWIN, 912 E LA SALLE ST SOUTH BEND 46617	OBG	258	GONZALES, SESINANDO, A, 2513 HIGHWAY AVE HIGHLAND 46322	OBG	174
GODERSKY, LOIS, GARNET S, 531 MAIN ST SOUTH BEND 46601	PTH	258	GONZALEZ LAGO, RAUL, C, 2900 W 16TH ST BEDFORD 47421	DR	182
GOEBEL, C, WM, 327 W CREIGHTON ST FORT WAYNE 46807	PDA	082	GONZALEZ, ALFREDO, B, 3901 SOUTH EAST ST INDIANAPOLIS 46227	GS	134
GOEL, ARUN, KUMAR, ROSS CLI-6111 HARRISON MERRILLVILLE 46410	IM	174	GOOD, RICHARD, PETERSON, 227 N FOREST DR KOKOMO 46901	OTO	126
GOEL, SARLA, KANAL, 7895 BROADWAY MERRILLVILLE 46410	PD	174	GOODE, ROBT, JAMES, U S 35 SOUTH KNOX 46534	GP	274
GOLD, MARVIN, E, 1005 CAMPBELL ST VALPARAISO 46383	ORS	230	GOODELL, CHAS, LEEPER, 308 WHITE RIBER BLVD MUNCIE 47303	NS	062
GOLDBERG, HAROLD, BENJ, 3656 GRANT ST GARY 46408	QS	174	GOODMAN, ELI, 807 HIGH ST CHARLESTOWN 47111	GP	034
GOLDBURG, BURT, RICHARD, 711 RIVER ROAD MARION 46952	OTO	098	GOODMAN, HUBERT, THORMAN, 220 GARDENDALE RD TERRE HAUTE 47803	PH	298
GOLDEN, WM, YOUNG, 914 SPRINGDALE JEFFERSONVILLE 47130	GP	034	GOODMAN, JULIUS, M, 1815 N CAPITOL INDIANAPOLIS 46202	NS	134
GOLDENBERG, DAVID, BARRON, 1815 N CAPITOL INDIANAPOLIS 46202	R	134	GOODWIN, THOS, GERALD, 6111 HARRISON MERRILLVILLE 46410	GP	174

GOOTEE, FRANCIS, HUGH, 501 CLAY ST JASPER 47546	FP	066	GRABER, RICHARD, R R #2 PAOLI 47454	FP	216
GOOTEE, THOS, H, 501 CLAY ST JASPER 47546	GP	066	GRABER, VIRGIL, R, 1400 HUDSON ST ELKHART 46514	OBG	070
GORDON, JAMES, DAVID, 5490 BROADWAY PLAZA MERRILLVILLE 46410	D	174	GRABOW, EMIL, FRANCIS, 7905 CALUMET AVE MUNSTER 46321	OPH	174
GORDON, JOS, LESTER, WHEELER 46393	GP	230	GRAESSLE, HAROLD, PETER, 640 EAST DR SEYMOUR 47274	GP	138
GORDON, MARK, 7905 CALUMET AVE MUNSTER 46321	D	174	GRAF, JEROME, ALEXANDER, 227 W MECHANIC ST BLOOMFIELD 47424	AN	102
GORDON, ROGER, DREW, 110 RIDGE ROAD MUNSTER 46321	FP	174	GRAF, JOHN, PAUL, 53260 PLACID DR SOUTH BEND 46637	AN	258
GORELIK, MARCOS, 110 RIDGE ROAD MUNSTER 46321	PDA	174	GRAF, RUSSELL, ENOCH, 1110 HIGHLAND PARK CIRCLE BLUFFTON 46714	R	318
GORMLEY, JOS, JAMES, 2372 LAFAYETTE RD INDIANAPOLIS 46222	GP	134	GRAFFIS, RICHARD, FRED, 1815 N CAPITOL INDIANAPOLIS 46202	GS	134
GOSMAN, JAMES, HUBERT, 1815 N CAPITOL INDIANAPOLIS 46202	D	134	GRAHAM, GEO, M, VILLA NO 5 5860 MIDNIGHT PASS RD SARASOTA FL 33581	OM	082
GOSSARD, JOHN, M, 2525 SOUTH STREET LAFAYETTE 47904	ORS	286	GRAHAM, JAMES, CLARENCE, 1834 S LAFAYETTE FORT WAYNE 46803	GP	082
GOSSARD, MEREDITH, B, 308 N INDEPENDENCE ST TIPTON 46072	GP	290	GRAHAM, JOHN, DOUGLAS, 1500 ALBANY STREET NO 912 BEECH GROVE 46107	IM	134
GOSSOM, DONN, ROBERTS, 825 N 3RD ST TERRE HAUTE 47807	GS	298	GRAHAM, NELSON, VERE, 3700 WASHINGTON AVE EVANSVILLE 47750	OBG	296
GOULD, JOHN, C C, 2424 FAIRFIELD FORT WAYNE 46807	GYN	082	GRAHAM, WM, EUGENE, 8402 N HARCOURT RD INDIANAPOLIS 46260	OBG	134
GOURIEUX, EDWARD, DE VERRE, 3700 BELLEMEADE SUITE 12C EVANSVILLE 47715	GP	296	GRAINGER, JAMES, LEWIS, 919 EAST JEFFERSON SOUTH BEND 46622	R	258
GRABER, ALVIN, RAY, 357 N NAPPANEE ST NAPPANEE 46550	GP	070	GRANDA, ARMANDO, BERNARDO, 3100 SUSAN DRIVE KOKOMO 46901	AN	126
GRABER, BENJ, ROBT, FAMILY DOCTOR CLINIC WATERLOO 46793	GP	058	GRANT, BENJ, FRANKLIN, 1706 BROADWAY GARY 46407	GP	174
GRABER, DONALD, D, 2600 OAKLAND AVE OAKLAWN CENTER ELKHART 46514	P	070	GRANT, M, ARTHUR, BOX 1088 MARION 46952	AN	098
GRABER, MARTIN, J, 101 N 17TH AVE BEECH GROVE 46107	FP	134	GRANT, PHYLLIS, ANN FENN, 530 S MAIN NEW CASTLE 47362	FP	122

GRAVES, NOEL, S, MADISON CLINIC MADISON 47250	GP	150	GREEN, WM, DOUGLAS, 221 S SIXTH ST TERRE HAUTE 47807	PD	298
GRAVES, ORVILLE, M, 125 W WALNUT ST PRINCETON 47670	GP	094	GREENBERG, BUKTON, HOWARD, 4321 FIR ST EAST CHICAGO 46312	CD	174
GRAY, HOWARD, R, 8801 N MERIDIAN ST SUITE 209 INDIANAPOLIS 46260	D	134	GREENE, MORGAN, E, 2014 WINCHESTER DR INDIANAPOLIS 46227	PUD	134
GRAY, KENNETH, LEE, 2727 N HIGH SCHOOL RD SPEEDWAY 46224	FP	134	GREENE, ROBT, WILKINS, 116 N CULLEN ST RENSSELAER 47978	GP	142
GRAY, LEON, 260 EAST MORGAN ST MARTINSVILLE 46151	IM	202	GREENE, WM, RAY, BOX 330 HENRYVILLE 47126	EM	034
GRAY, WAYNE, LEE, 3729 W JACKSON MUNCIE 47304	CD	062	GREENLEE, JAMES, ROBT, 236 SIMPSON ELKHART 46514	GYN	070
GRAYSON, FRED, EDWIN, 513 RIDGE RD MUNSTER 46321	U	174	GREENLEE, ROBT, L, 909 E STATE BLVD FORT WAYNE 46805	CHP	082
GRAYSON, MERRILL, I U MEDICAL CENTER INDIANAPOLIS 46202	OPH	134	GREGOLINE, EUGENE, PAUL, 8127 MERRILLVILLE ROAD MERRILLVILLE 46410	OBG	174
GRAYSON, TED, LINDSAY, 2020 W 86TH ST SUITE 301 INDIANAPOLIS 46260	GS	134	GREGORY, ROBT, LEON, 5506 E 16TH INDIANAPOLIS 46218	DIA	134
GREEN, EDWARD, WHITMAN, 421 CHESTNUT ST EVANSVILLE 47713	PD	296	GREISEN, JACK, CHAS, 2075 INDIANAPOLIS BLVD WHITING 46394	GP	174
GREEN, GEO, F, 601 JMS BLDG SOUTH BEND 46601	GS	258	GREIST, JOHN, H, 3231 N MERIDIAN INDIANAPOLIS 46208	P	134
GREEN, GEO, RICHARD, 601 J M S BLDG SOUTH BEND 46601	GS	258	GRIEF, ROBT, STEELE, 2302 E TROY INDIANAPOLIS 46203	GP	134
GREEN, JAN, C, 513 NORTH MICHIGAN ST SOUTH BEND 46601	U	258	GRIEP, ARTHUR, H, 5414 MADISON AVE EVANSVILLE 47715	CD	296
GREEN, LEONARD, JUDSON, 1005 CAMPBELL VALPARAISO 46383	GP	230	GRIEP, JOHN, ARTHUR, 1100 W MICHIGAN ST INDIANAPOLIS 46202	PTH	134
GREEN, MORRIS, I U MEDICAL CENTER INDIANAPOLIS 46202	PD	134	GRIES, RICHARD, LAWRENCE, R R 1 HAVEN DR HAUBSTADT 47639	FP	296
GREEN, NORVAL, E, 513 NORTH MICHIGAN ST SOUTH BEND 46601	U	258	GRIEST, WALTER, DIXON, 3024 FAIRFIELD AVE FORT WAYNE 46807	PTH	082
GREEN, OSCAR, P O BOX 40506 INDIANAPOLIS 46240	OTO	134	GRIFFIN, CHAS, G, 1101 GLENDALE VALPARAISO 46383	GS	230
GREEN, ROBT, F, 614 W BERRY ST FORT WAYNE 46802	P	082	GRIFFIN, JOS, PATRICK, 419 JACKSON BLVD CHESTERTON 46304	A	230

GRIFFIN,LESLIE,WM, 3203 W 57TH ST INDIANAPOLIS 46208	OM	134	GROVE,DEAN,ALLEN, 3411 BRIAR CIRCLE CARMEL 46032	GER	134
GRIFFITH,HAROLD,RILEY, 1913 FOREST PARK BLVD FORT WAYNE 46805	R	082	GRUBER,CHAS,M, MARION CO GENERAL HOSPITAL INDIANAPOLIS 46202	OS	134
GRIFFITH,JOEL,HAROLD, 2801 NORTH WALNUT ST BLOOMINGTON 47401	P	214	GUCKIEN,JOS,LAWRENCE, 611 HARRIET ST EVANSVILLE 47710	OPH	296
GRIFFITH,RICHARD,S, 2002 CUNNINGHAM RD INDIANAPOLIS 46224	US	134	GUEVARA,FRENITA,BERNAL, MARION HOSPITAL MARION 46952	GP	098
GRIFFITH,ROSS,EARL, 801 KESSLER BLVD W DR INDIANAPOLIS 46208	ObG	134	GUEVARA,TEODORO,G, 1251 KEM ROAD MARION 46952	IM	098
GRILLO,DONALD, 214 SHERLAND BLDG SOUTH BEND 46601	CRS	258	GUILD,J,KENT, 116 E WASHINGTON ST PLYMOUTH 46563	GP	190
GRIMES,EVA,M, 6001 BUCKSKIN CIRCLE INDIANAPOLIS 46250	DK	134	GUIN,JERE,DONALD, 804 S BERKLEY RD KOKOMO 46901	D	126
GRIMES,HUBERT,N, 5516 E 21ST INDIANAPOLIS 46218	PD	134	GUINIGUNDO,NOLI,C, HIDDEN VALLEY LANE RR 4 BROOKVILLE 47012	FP	074
GRIMM,WM,CHAS HERBERT, 421 CHESTNUT ST EVANSVILLE 47713	IM	296	GUMBERT,JACK,LEE, 5010 RIVIERA CT FORT WAYNE 46805	GS	082
GRIPE,RICHARD,PUTNAM, 2600 GREENBUSH ST LAFAYETTE 47902	CU	286	GUNDERSON,SHAUN,DENNIS, 60301 C R 19 GOSHEN 46526	R	070
GRISELL,TED,LEWIS, 5317 E 16TH ST INDIANAPOLIS 46218	GS	134	GUSTAFSON,MILTON,HENRY F, 2606 W JACKSON ST MUNCIE 47303	D	062
GRISELL,TED,WOOD, R R 1 BOX 812 CARMEL 46032	CDS	134	GUSTAITIS,JOHN,WM, 7905 CALUMET AVE MUNSTER 46321	DR	174
GRORUD,ALTON,CLAREN, 919 EAST JEFFERSON BLVD #401 SOUTH BEND 46622	IM	258	GUTHRIE,JAMES,U, 331 W 3RD ST PERU 46970	GS	194
GROSFELD,JAY,L, 1100 W MICHIGAN ST RILEY HOSP INDIANAPOLIS 46202	PDS	134	GUTIERREZ,GERMAN, SOUTHERN HILLS MENTAL HEALTH MONTE BUILDING JASPER 47546	P	066
GROSS,JOS,OSCAR, 7905 CALUMET AVE MUNSTER 46321	PD	174	GUTIERREZ,PETER,EMANUEL, 12110 GRANT CROWN POINT 46307	GP	174
GROSSO,WM,GEO, 1919 E COLUMBUS DR EAST CHICAGO 46312	GP	174	GUTMANN,GORDON,LIEBREICH, 207 SPARKS AVE JEFFERSONVILLE 47130	GS	034
GROSZ,HANUS,JIRI, IND UNIV MED CTR PSY RES INDIANAPOLIS 46202	P	134	GUTTMAN,JOHN,BECK, BOX 146 WAKARUSA 46573	GP	070
GROTHOUSE,CARL,B, 400 S BERKLEY RD KOKOMO 46901	ORS	126	GUTWEIN,GILBERT, 2525 SOUTH ST LAFAYETTE 47904	ORS	286

GUZMAN,MARCELINO,F, 331 W BEAVER ST MOROCCO 47963	GP	204	HAGGARD,DAVID,BENSON, 301 S EAST ST PLAINFIELD 46168	GP	118
H HA,YOUNG,JAЕ, 604 N MICHIGAN ST SOUTH BEND 46601	AN	258	HAGGERTY,FRED,EMMETT, 600 N ARLINGTON STE E GREENCASTLE 46135	GP	242
HAAS,CHAS,F, 2500 FERRY LAFAYETTE 47904	D	286	HAGUE,JOHN,MAURICE, 8330 NAAB ROAD INDIANAPOLIS 46260	IM	134
HAAS,RAY,ALLAN, 120 WEST MC KENZIE GREENFIELD 46140	FP	110	HAHN,JOHN,JOONYONG, 316 SHERLAND BLDG SOUTH BEND 46601	AN	258
HABANSKY,ALAN,J, 412 WHITERIVER PKWY MUNCIE 47302	ORS	062	HAICK,EDWARD, 3116 RUNNYMEDE ROAD LOUISVILLE KY 40222	R	262
HABBE,TIMOTHY,ALAN, 711 W 2ND ST BLOOMINGTON 47401	U	214	HAINES,DAVID,W, 2235 DUBOIS DR WARSAW 46580	GP	166
HABEGGER,ELMER,D, 8330 NAAB ROAD INDIANAPOLIS 46260	GS	134	HAKAMI,MOHAMED,TAGHI, HUNTINGBURG CLINIC HUNTINGBURG 47542	OBG	066
HABERMEL,JOHN,FRANKLIN, 908 SPRING ST NEW ALBANY 47150	CD	076	HALABY,FOUAD,ASSAD, 700 BROADWAY FORT WAYNE 46802	R	082
HACKETT,WALTER,GEO, 3610 BROOKLYN AVE FORT WAYNE 46807	GP	082	HALBROOK,HAROLD,G, 1815 NORTH CAPITOL AVE INDIANAPOLIS IN 46202	GS	134
HADDAD,ROLANDO,IGNACIO, 207 WEST 13TH ST JEFFERSONVILLE 47130	P	034	HALEY,ALVIN,JOHN, 3217 LAKE AVE FORT WAYNE 46805	FP	082
HADDAWI,RAJIH,Y, 515 WOODCREST DR BLOOMINGTON 47401	OKS	214	HALEY,GEO,MATSON, 220 SHERLAND BLDG SOUTH BEND 46601	U	258
HADEY,JAMES,H, 6111 HARRISON ST MERRILLVILLE 46410	OBG	174	HALEY,PAUL,EDWARD, 301 LE BLVD DE LA PAIR 2901 SOUTH BEND 46615	GS	258
HADIDIAN,HENRY,ARAM, 3680 A 179TH ST HAMMOND 46323	CDS	174	HALFAST,RICHARD,W, 400 S BERKLEY RD KOKOMO 46901	ORS	126
HADLEY,DAVID, 5601 N PENNSYLVANIA INDIANAPOLIS 46220	ORS	134	HALL,BERNARD,RICHARD, 1201 MICHIGAN AVE STE D LOGANSPORT 46947	OBG	030
HADLEY,DAVID,M, 301 S EAST ST PLAINFIELD 46168	FP	118	HALL,DONALD,LURVE, 701 NORTH 7TH ST PETERSBURG 47567	FP	226
HAFFNER,HERMAN,GEO, 202 E JEFFERSON ST FORT WAYNE 46802	D	082	HALL,JACK,HUETT, METHODIST HOSPITAL INDIANAPOLIS 46202	CD	134
HAGAN,MARION,LUTHER, 307 MAIN ST FRENCH LICK 47432	GP	210	HALL,THOS,CHAS, 621 BROADWAY CHESTERTON 46304	GP	230
HAGENOW,CHAS,FREDERICK, 66 KESTON ELM DR LA PORTE 46350	FP	178	HALL,WM,RICHARD, 5800 FAIRFIELD AVE WORTHMAN MALL NO 150 FORT WAYNE 46807	AN	082

HALLAL, ELI, 2580 CHARLESTOWN ROAD NEW ALBANY 47150	GP	078	HAMMITT, KARLEEN, BASCOM, MADISON STATE HOSPITAL MADISON 47250	P	150
HALLECK, HAROLD, JEROME, 119 W MAIN ST WINAMAC 46996	GP	238	HAMMOND, R, CASE, 611 HARRIET ST APT 504 EVANSVILLE 47710	U	296
HALLER, ROBT, LEWIS, KEMPTON CLINIC KEMPTON 46049	GP	290	HAMMOND, STANLEY, MEAD, 7905 CALUMET AVE MUNSTER 46321	P	174
HALUM, RAMON, GAYLON, 800 MAC ARTHUR BLVD SUITE 1 MUNSTER 46321	U	174	HAMPSHIRE, DONALD, ROSS, 955 NORTH PENNSYLVANIA ST INDIANAPOLIS 46204	GP	134
HAMAKER, RONALD, CLAIR, 10821 BRAEWICK DR CARMEL 46032	HNS	134	HAMPTON, JAMES, NICHOLS, 530 N MICHIGAN ST ARGOS 46501	GP	190
HAMANG, PETER, MICHAEL, 904 W RIDGE RD MOBART 46342		174	HAN, DANL, 12317 KINGFISHER RD CROWN POINT 46307	PTH	174
HAMBURGER, RICHARD, JAMES, 1100 W MICHIGAN ST INDIANAPOLIS 46202	NEP	134	HANKIN, LAWRENCE, G, 110 RIDGE ROAD MUNSTER 46321	U	174
HAMILTON, CHAS, O, 604 N MICHIGAN SOUTH BEND 46601	AN	258	HANNAH, JACK, WM, 1906 E JACKSON BLVD ELKHART 46514	AN	070
HAMILTON, EMORY, D, 5800 FAIRFIELD STE 150 FORT WAYNE 46807	AN	082	HANNEKEN, VINCENT, JOHN, 400 ASH ST WABASH 46992	GP	302
HAMILTON, GEO, MILTON, 3124 E STATE BLVD FORT WAYNE 46805	IM	082	HANNEMANN, ROBT, EARL, 2600 GREENBUSH ST LAFAYETTE 47902	PD	280
HAMILTON, JAMES, ROBT, MITCHELL 47446		182	HANSELL, CHAS, EARL, 3367 LAUREL WAY BEALE AFB CA 95903	FP	082
HAMILTON, THOS, G, BOX 508 COLUMBIA CITY 46725	GP	326	HANSON, MARTIN, F, 100 N 1ST ST ELWOOD 46036	GP	186
HAMM, CHAS, W, 3566 W 71ST INDIANAPOLIS 46268	PD	134	HARCOURT, ROBT, SHAW, 1915 N CAPITOL AVE INDIANAPOLIS 46202	HS	134
HAMMEL, HOWARD, TRUE, R R 2 SPRINGVILLE 47462	GP	182	HARDEN, MURRAY, E, 401 SHARON RD WEST LAFAYETTE 47906	OBG	286
HAMMER, JAY, WM, 1323 E 1ST ST BLOOMINGTON 47401	R	214	HARDIN, STEPHEN, LEE, R R 8 FOXCLIFF ESTATES MARTINSVILLE 46151		202
HAMMER, MICHAEL, 7018 INDIANAPOLIS BLVD HAMMOND 46324	OBG	174	HARDIN, WAYNE, EMERSON, 102 METTS ST OSSIAN 46777	GP	318
HAMMER, TODD, JEROME, 1804 BELMONT DR MUNCIE 47304	FP	062	HARDING, JOHN, SCOTT, 3533 SPRINGBROOK DR SOUTH BEND 46614	DR	258
HAMMERSLEY, GEO, K, 1201 S OAK ST FRANKFORT 46041	GS	042	HARDING, M, RICHARD, 8801 NORTH MERIDIAN ST NO 107 INDIANAPOLIS 46260	OPH	134

HARE,DANL,M, 5029 LINCOLN AVE EVANSVILLE 47715	U	296	HARRIS,ROBT,LEE, 801 ST MARYS DR SUITE 305 ST MARY MED BLDG EVANSVILLE 47715	FP	296
HARE,FRANCIS,WILLIAMS JR, 722 W MAIN ST MADISON 47250	IM	150	HARRIS,WM,DUANE, 27 CAMDEN COURT EVANSVILLE 47715	AN	296
HARE,LAURA, 87 W 43RD ST INDIANAPOLIS 46208	IM	134	HARSHMAN,JAMES,ALAN, ST JOSEPH HOSP KOKOMO 46901	PTH	126
HARGER,ROBT,WM, 115 NORTH PENN INDIANAPOLIS 46204	OPH	134	HARSHMAN,LOUIS,POTTER, 1555 N MAIN ST FRANKFORT 46041	P	082
HARGETT,HERBERT,P, 438 SPRING ST JEFFERSONVILLE 47130	OPH	034	HARSTAD,CASPER, 216 W HIGH ST ROCKVILLE 47872	GP	218
HARGETT,ISAAC,REYNOLDS, 421 CHESTNUT ST EVANSVILLE 47713	PD	296	HART,ROBT,BRUCE, 915 WASHINGTON ST COLUMBUS 47201	GP	014
HARLESS,CLARENCE,MINOR, 445 FRANKLIN ST CHESTERTON IN 46304	GP	230	HARTER,ELI,BLAIR, 918 KING ST LAFAYETTE 47905	AM	286
HARLOWE,STUART,E, 15 TRIMINGHAM RD NEW ALBANY 47150	U	078	HARTLEY,CLARENCE,A, 221 CHESTNUT ST EVANSVILLE 47713	GP	296
HARMON,CARL,JOS, 311 MED ARTS BLDG RICHMOND 47374	GP	314	HARTMAN,CLAUDE,EDWARD, 515 NORTH RIVERSIDE DR ELKHART 46514	OBG	070
HARMON,THOS,MAITLAND, R R 8 BROWNING RD EVANSVILLE 47711	R	296	HARTMAN,JOHN,J, 909 W MAUMEE ST ANGOLA 46703	ABS	278
HARNDEN,HURLBUT,L, 426 E MAIN ST MADISON 47250	GS	150	HARTSOUGH,RALPH,I, 24078 STANTON RD NORTH LIBERTY 46554	EM	258
HARNED,BEN,K, 421 CHESTNUT ST EVANSVILLE 47713	GS	296	HARTZ,F,MINTON, 7321 TAYLOR EVANSVILLE 47715		296
HARRIS,C,GLENN, 711 E COLFAX AVE SOUTH BEND 46617	P	258	HARVEY,BENNETT,BROWN, 2500 FERRY ST LAFAYETTE 47904	PTH	286
HARRIS,CARL,BENJ, 833 W MAIN ST CARMEL 46032	OPH	134	HARVEY,DAVID,M, 716 SEBERGER DR MUNSTER 46321	URS	174
HARRIS,GEO,F, HILLTOP MED CTR MADISON 47250	GP	150	HARVEY,HARRY,C, METHODIST HOME FRANKLIN 46131	GS	082
HARRIS,JAMES,JAY, 3217 LAKE AVE FORT WAYNE 46805	FP	082	HARVEY,JOHN,CHRISTIE, 405 S MAIN ST AUBURN 46706	GP	058
HARRIS,NEIL,REVERE, 307 S 7TH ST GOSHEN 46526	GP	070	HARVEY,RALPH,JOHNS, 95 S 3RD ST ZIONSVILLE 46077	GPM	022
HARRIS,PAUL,NOEL, 4114 E 65TH ST INDIANAPOLIS 46220	PTH	134	HARVEY,VERNE,K, RR 2 BOX 292 ZIONSVILLE 46077	GPM	022

HARVEY, VERNE, K, 3601 WEST 69TH ST INDIANAPOLIS 46268	PH	134	HAWES, MARVIN, E, R R 1 BOX 59 HOPE 47246	CD	014
HASEWINKEL, CARROLL, WEBER, R D 2 BOX 354 CARMEL 46032	AN	134	HAWK, EDGAR, A, 7328 HUNTINGTON RD INDIANAPOLIS 46240	AN	134
HASEWINKLE, AUGUST, M, 2828 E STATE BLVD FORT WAYNE 46805	IM	082	HAWK, JAMES, HUBER, 26 WEST LAVEROCK ROAD INDIANAPOLIS 46208	OBG	134
HASHEMI, HOSSEIN, 602 S BUFFALO WARSAW 46580	GS	166	HAWKINS, RICHARD, DALE, EDGEWOOD CLINIC BEDFORD 47421	PD	182
HASLEM, JOHN, ROBT, 221 S 6TH ST TERRE HAUTE 47807	GS	298	HAY, GENE, R, 1225 E COOLSPRING AVE MICHIGAN CITY 46360	IM	178
HASS, CAROLINE, E HALL, 316 N SALISBURY WEST LAFAYETTE 47906	GP	286	HAYES, THEODORE, R, 520 W MAIN ST MUNCIE 47305	U	062
HASS, THOS, W, 316 N SALISBURY WEST LAFAYETTE 47906	OBG	286	HAYES, THOS, P, DEACONESS HOSP EVANSVILLE 47710	TR	296
HASSEL, WALTER, BETHEL, 3712 HERNDON DR EVANSVILLE 47711	OBG	296	HAYHURST, THOS, ELTON, 2828 FAIRFIELD AVE FORT WAYNE 46807	PUD	082
HASTINGS, WARREN, C, 2120 CAREW ST FORT WAYNE 46805	NS	082	HAYMOND, GEO, M, 600 E WINONA AVE WARSAW 46580	GS	166
HASWELL, JOHN, NOBLE, 607 DU BUIS ST VINCENNES 47591	OBG	162	HAYMOND, JOS, LAYTON, 301 E 38TH ST INDIANAPOLIS 46205	PTH	134
HATCHER, CHAS, MONTE, 2127 DOCTORS PARK DR COLUMBUS 47201	FP	014	HAYNES, JOHN, THOS, 1815 N CAPITOL INDIANAPOLIS 46202	A	134
HATFIELD, NICHOLAS, W, 5851 E 54TH PL INDIANAPOLIS 46226	OS	134	HAZELRIGG, DONALD, EDWIN, 421 CHESTNUT ST EVANSVILLE 47713	D	296
HATHAWAY, CLAYTON, B, 1005 NICHOLAS ST AUBURN 46706	GP	058	HEALEY, ROBT, J, 5559 WASHINGTON BLVD INDIANAPOLIS 46220	GE	134
HATHAWAY, WM, HENRY, 1005 NICHOLAS ST AUBURN 46706	GP	058	HEALY, CORNELIUS, EDWARD, 421 CHESTNUT ST EVANSVILLE 47713	PD	296
HATHWAY, STEPHEN, DALLAS, 531 NORTH MAIN ST SOUTH BEND 46601	PTH	258	HEATON, ELTON, 1950 VALLE VISTA CT MADISON 47250	PTH	150
HATTENDORF, A, PAUL, 4041 OLD MILL ROAD FORT WAYNE 46807	PH	082	HEAVRIN, JOHN, SLOAN, 1630 S OHIO ST MARTINSVILLE 46151	OBG	202
HAUERSPERGER, ALFRED, D, 2756 25TH ST COLUMBUS 47201	OPH	014	HECK, LARRY, LEE, 2103 WHITEWOOD COURT INDIANAPOLIS 46260	NM	134
HAVENS, RUSSELL, E, 3721 INWOOD DR FORT WAYNE 46805	AN	082	HECKAMAN, EDWARD, LENTZ, RICHMOND STATE HOSP RICHMOND 47374	OS	314

EDGCOCK,ROBT,ANDREW, 259 E CLINTON ST FRANKFORT 46041	GP	042	HEMPHILL,ROGER,ANDREW, 7607A SOMERSET BAY INDIANAPOLIS 46240		098
EDRICK,JAMES,T, 2200 GRANT ST GARY 46404	GP	174	HENDERSHOT,EUGENE,L, 401 S E 6TH ST EVANSVILLE 47713	R	296
EDRICK,PHILIP,WM, 1221 E 86TH ST INDIANAPOLIS 46240	PD	134	HENDERSON,NORMAN,CHAS, P O BOX 586 MICHIGAN CITY 46360	UTU	178
EGEMAN,THEODORE,FAYNE, 12204 CASTLE ROW OVERLOOK CARMEL 46032	IM	134	HENDERSON,ROSCOE,C, 101 E 34TH ST INDIANAPOLIS 46205	GP	134
EHMANN,WM,VINCENT, 7905 CALUMET AVE MUNSTER 46321	FF	174	HENDERSON,TERRY,LYNN, 8330 NAAB RD INDIANAPOLIS 46260	Fr	134
EID,GEO,J, 2500 FERRY ST LAFAYETTE 47904	FUP	286	HENDRICKS,FRED,ARTHUR, 6917 N KEYSTONE INDIANAPOLIS 46220	FP	134
HEIDEMAN,HARRY,DAVID, 1220 MISSOURI AVE JEFFERSONVILLE 47130	R	034			
HEILMAN,WM,CLYDE, 1007 NORTH 16TH ST NEW CASTLE 47362	GP	122	HENDRIX,CHAS,E, PO BOX 686 VINCENNES 47591	IM	162
HEIMBURGER,IRVIN,LE ROY, 611 HARRIET ST STE 501 EVANSVILLE 47710	TS	296	HENN,RAY,ANTHONY, 137 W MICHIGAN ST GREENFIELD 46140	GP	110
HEINLEIN,CARL,LORISTON, 155 WEST MARION ST DANVILLE 46122	GP	118	HENRY,ALVIN,L, 1930 DOCTORS PARK DR COLUMBUS 47201	OPH	014
HEINRICH,WESTON,A, 314 S E RIVERSIDE DR EVANSVILLE 47713	GS	296	HENRY,HOWARD,JENNINGS, 107 S MAIN ST KNOX 46534	GS	274
HEISER,ERVIN,WM, 1400 HUDSON ST ELKHART 46514	OBG	070	HENRY,RUSSELL,SELDON, 4715 RYDAL COURT INDIANAPOLIS 46254	PJD	134
HELD,GEO,ARTHUR, 51 PINE DR-CHRISTMAS LAKE VILL SANTA CLAUS 47579	GP	066	HENSLER,BENTON,MOSES, 1415 RAIBLE AVE ANDERSON 46011	GP	186
HELMEN,CHAS,H, 5269 ROLAND DR INDIANAPOLIS 46208	R	134	HENSLEY,HARRY,THOS, 11929 E 65TH ST OAKLANDON 46236	GP	110
HELMER,JOHN,FRANCIS, 2116 AMERICAN NATL BANK BLDG SOUTH BEND 46601	GS	258	HEPNER,HERMAN, 705 N STATE ST KENDALLVILLE 46755	GP	206
HELMS,CHAS,EDWARD, 110 RIDGE RD MUNSTER 46321	GS	174	HERBST,JERRY, 221 S 6TH ST TERRE HAUTE 47807	U	298
HELVESTON,EUGENE,M, INDIANA UNIV MED CENTER INDIANAPOLIS 46202	OPH	134	HERENDEN,THOS,LEE, 3124 E STATE BLVD FORT WAYNE 46805	GS	082
HELVIE,JANICE,L, DOCTORS PARK NO 2 COLUMBUS 47201	GPM	014	HERITIER,CLAUDE,J, 700 HILL DR COLUMBIA CITY 46725	GP	326

HERMAN,DANIEL,J, 609 DU BOIS ST VINCENNES 47591	ORS	162	HIBBELN,THOS,J, 206 MEADOW DR DANVILLE 46122	GS	11
HERMAN,JEAN,TUCKER, 7780 MICHIGAN RD INDIANAPOLIS 46268	N	134	HIBBS,WM,GEO, R R 1 FRANKLIN 46131	IM	15
HERMANN,HAROLD,WESLEY, 1508 REDWING DR EVANSVILLE 47715	OS	296	HIBNER,DAN,WM, 1020 NORTH J ST RICHMOND 47374	FP	31
HERMAYER,STEPHEN, 220 S E 7TH ST EVANSVILLE 47713	OPH	296	HICKMAN,DONALD,M, 3217 LAKE AVE FORT WAYNE 46805	GP	08
HERNANDEZ,ILUMINADA,C, 1802 COLUMBUS DR EAST CHICAGO 46312	GP	174	HICKS,GEO,WM, 5506 E 16TH INDIANAPOLIS 46218	OTO	134
HEROD,GILBERT,THOS, 1815 N CAPITOL AVE INDIANAPOLIS 46202	TS	134	HICKS,MURWYN,LEO, 5434 EMERSON WAY SUITE NO 115 INDIANAPOLIS 46226	AN	134
HERRBERG,JEROME,EDWARD, 2525 SANDCREST BLVD COLUMBUS 47201	FP	014	HICKS,THOS,JOS, 2200 LAKE AVE SUITE 150 FORT WAYNE 46805	K	082
HERRELL,MICHAEL,ALAN, 3700 WASHINGTON AVE EVANSVILLE 47750	PTH	296	HIEBER,FRANK,REYNOLDS, 7905 CALUMET AVE MUNSTER 46321	IM	174
HERRICK,CHAS,LISLE, AKRON 46910		090	HIGGINS,JACK,WAYNE, 804 BERKLEY RD KOKOMO 46901	FP	126
HERRING,MALCOLM,B, 2001 W 86TH ST INDIANAPOLIS 46260	GS	134	HIGGINS,JAMES,LEMMON, 524 MARTINS LANE EVANSVILLE 47715	GP	296
HERRMANN,GORDON,T, 3700 BELLEMEADE AVE EVANSVILLE 47715	IM	296	HIGGINS,JOHN,ROBINSON, 700 EAST SPRING STREET NEW ALBANY 47150	GS	078
HERSHBERGER,PHILIP,G, 2609 FAIRFIELD AVE FORT WAYNE 46807	ORS	082	HIGH,RALPH,LESLIE, 420 W WASHINGTON ST MUNCIE 47305	DBG	062
HERZBERG,MILTON, 222 ELM ST CLINTON 47842	GP	218	HILBERT,JOHN,W, 1505 MARIGOLD WAY NO 307 SOUTH BEND 46617	OS	258
HERZER,CLARENCE,C, 211 EAST MILL RD EVANSVILLE 47711	GP	296	HILDEBRAND,JOHN,O, 1307 E EWING AVE SOUTH BEND 46613	FP	258
HEUBI,JOHN,E, 6904 N PARK AVE INDIANAPOLIS 46220	PD	134	HILDEBRAND,WM,LEE, 6037 EAST 10TH ST INDIANAPOLIS 46219	GP	134
HEUMANN,JOHN,E, 611 HARRIET ST NO 401 EVANSVILLE 47715	ORS	296	HILL,HERBERT,NOBLE, 3500 LAFAYETTE ROAD INDIANAPOLIS 46222	FP	134
HEYMANN,ROBT,LAWRENCE, 300 NE 14TH WASHINGTON 47501	GS	046	HILL,JAMES,K, 8801 NORTH MERIDIAN ST INDIANAPOLIS 46260	A	134
HIBBELN,FREDERIC,P, 8402 N HARCOURT RD APT 211 INDIANAPOLIS 46260	D	134	HILL,JAMES,STEPHEN, 2828 FAIRFIELD FORT WAYNE 46807	PD	082

HILL, KENNETH, GRIMES, 710 S 14TH NEW CASTLE 47362	FP	122	HINCHMAN, JEAN, FRANCIS, PARKER 47368	GP	062
HILL, LLOYD, LEONH, 302 N DUKE ST PERU 46970	GP	194	HINES, JOHN, HENRY, 403 S MAIN AUBURN 46706	GP	058
HILL, PAUL, GOODWIN, 5 N FOOTE CAMBRIDGE CITY 47327	GP	314	HINES, KENNETH, EARLE, 911 S INDIANA AVE SELLERSBURG 47172	GP	034
HILL, THEODORE, ALBERT, 1606 LAKE SHORE DR MICHIGAN CITY 46360	P	178	HINSHAW, MICHAEL, ANTHONY, 1250 CHESTER BLVD RICHMOND 47374	GS	314
HILL, WALLACE, CLARK, 919 E JEFFERSON BLVD SOUTH BEND 46622	GS	258	HIPPENSTEEL, HARLAND, V, P O BOX 107 AUBURN 46706	GP	058
HILLENBRAND, CHAS, JOHN, 128 W 10TH ST MICHIGAN CITY 46360	P	178	HIRSCH, MELVIN, LEONARD, P O BOX 96 37 JOLIET ST DYER 46311	IM	174
HILLERY, ROBT, LEE, 5020 MORSH RD FORT WAYNE 46825	FP	082	HIRSCH, THEODORE, R R 6 CONNERSVILLE 47331	R	074
HILLIS, J, STANLEY, 8402 HARCOURT RD NO 717 INDIANAPOLIS 46260	CD	134	HITCHCOCK, LARRY, GEO, 7111 EASTWICK LANE INDIANAPOLIS 46256	U	134
HILLIS, LOWELL, JOS, 718 E BROADWAY LOGANSPOET 46947	GP	030	HITCHCOCK, PHILIP, DUDLEY, 900 ROYAL AVE EVANSVILLE 47715	GP	296
HILLMAN, MARION, W, 1728 LITTLEPOINTE CIRCLE SARASOTA FL 33581	GP	258	HOBBS, ARTHUR, A, 200 TYLER EVANSVILLE 47715	R	296
HILTON, FRANK, LINDEN, 326 S E 7TH EVANSVILLE 47713	DBG	296	HOBBS, HUDNER, L S, 652 N GIRLS SCHOOL RD NO 110 INDIANAPOLIS 46224	PD	134
HILZ, JAMES, MICHAEL, 6550 YELLOWSTONE PKWY INDIANAPOLIS 46217	TS	134	HODEL, HARRY, LEONARD, 7715 COVE CT INDIANAPOLIS 46234	R	134
HILZ, MARY, ANN CORTESE, 6550 YELLOWSTONE PKY INDIANAPOLIS 46217	R	134	HODGES, CHAS, DAVID, 905 NORTH LEBANON ST LEBANON 46052	FP	022
HIMEBAUGH, GILBERT, JOS, 801 ST MARYS DR NO 307 EVANSVILLE 47715	GS	296	HODGIN, PHILLIP, THOS, ORLEANS 47452	FP	210
HIMELSTEIN, NATHANIEL, H, 3500 N LAFAYETTE RD INDIANAPOLIS 46222	FP	134	HODONOS, PHILLIP, ELI, 1225 E COOLSPRING AVE MICHIGAN CITY 46360	GP	178
HIMLER, JAMES, MURAT, 8015 BLUFF RD INDIANAPOLIS 46217	IM	134	HOETZER, ELDORE, MARTIN, 502 HENRY ST NEW HAVEN 46774	GP	082
HIMMELSBACH, WM, ANTHONY, MILES LAB INC ELKHART 46514	OM	070	HOFFMAN, ARTHUR, F, THREE RIVERS APT N RM 105 FORT WAYNE 46802	AN	082
HINCHEN, JAMES, EDWARD, 313 EAST UNION ST LIBERTY 47353	FP	314	HOFFMAN, MAX, NORMAN, 416 UNION ST COVINGTON 47932	GP	086

HOGAN, MICHAEL, ARTHUR, 7514 BROOKVIEW CIRCLE INDIANAPOLIS 46250	PL	134	HOLMES, JOHN, LOUIS, 412 WHITE RIVER BLVD MUNCIE 47303	OKS	062
HOGAN, THOS, W, P O BOX 186 TERRE HAUTE 47803	R	298	HOLTZCLAW, DAVID, LESLIE, 413 W FIRST ST BLOOMINGTON 47401	PD	214
HOGLE, FRANK, D, 15 POHCHARTRAIN MICHIGAN CITY 46360	P	178	HOLTZMAN, NORMAN, N, 514 MAPLE LANE BATAVIA IL 60510	IM	258
HOHAM, FREDERICK, DIXON, 2674 PORTAGE MALL PORTAGE 46368	GP	230	HOLTZMAN, PAUL, WM, 113 S LINCOLN ST BLOOMINGTON 47401	IM	214
HOIT, LEONARD, 1000 E 80TH MERRILLVILLE 46410	D	174	HOLWERDA, HARRY, LEE, DE MOTTE PHYSICIANS INC DEMOTTE 46310	GP	230
HOLDEMAN, LILLIAN, SCHEIB, R R 3 BOX 203 EAGLE LAKE EDWARDSBURG MI 49112	PH	258	HONAN, PAUL, REVERE, 1720 N LEBANON ST LEBANON 46052	OPH	022
HOLDEMAN, RICHARD, W, 404 N LAFAYETTE BLVD SOUTH BEND 46601	IM	258	HOOD, AINSLEE, A, 1810 ROSEDALE INDIANAPOLIS 46227	EM	134
HOLDEN, ROBT, WATSON, R R 1 BOX 575 PLAINFIELD 46168	R	014	HOOD, TONY, EUGENE, 660 MARY ST DEACONESS HOSP EVANSVILLE 47710	AN	296
HOLDREAD, JON, WAYNE, 2510 SANDCREAST BLVD COLUMBUS 47201	P	014	HOOG, JOHN, MICHAEL, 527 W BERRY ST FORT WAYNE 46802	U	082
HOLL, CARL, W, 106 D SHORELINE CT NOBLESVILLE 46060	R	186	HOOKE, DONALD, J, 104 S MAIN LIGONIER 46767	GP	206
HOLLAND, WM, MARTIN, 3524 N MERIDAN ST INDIANAPOLIS 46208	IM	134	HOOKE, REX, RAYMOND, 8354 CRESTWOOD MUNSTER 46321	GS	174
HOLLENBERG, ALFRED, E, 700 N WASHINGTON ST HAGERSTOWN 47346	GP	314	HOOPES, JANE, MAC LEOD, RR 8 BOX 95 EVANSVILLE 47711	PD	296
HOLLENBERG, EDWARD, L, 613 TERRACE DR WINAMAC 46996	FP	238	HOOVER, J, GUY, 611 HARRIET ST-STE 501 EVANSVILLE 47710	GS	296
HOLLIDAY, ALFONSO, DAVID, 919 NORTH UNION ST GARY 46403	GS	174	HOOVER, JOSEPH, ROYAL, 3610 BROOKLYN AVE FORT WAYNE 46809	GP	082
HOLLOWAY, RICHARD, JAMES, 211 N EDDY ST SOUTH BEND 46617	U	258	HOOVER, PETER, BOWEN, 223 W LOCUST ST BOONVILLE 47601	GP	306
HOLM, BYRON, MARSH, 304 NORTH WALNUT ST PLYMOUTH 46563		190	HOPKINS, BRUCE, JORDAN, 8402 HARCOURT RD STE 208 INDIANAPOLIS 46260	OTO	134
HOLMAN, JEROME, E, 6127 NORTH COLLEGE AVE INDIANAPOLIS 46220	OS	134	HORNBACK, NED, B, I U MEDICAL CENTER INDIANAPOLIS 46202	TR	134
HOLMAN, JEROME, EARL, 3315 EAST 10TH ST INDIANAPOLIS 46201	GP	134	HORNER, TERRY, GRANT, 8153 WELLSBROOK DR INDIANAPOLIS 46278	NS	134

ORNING,RICHARD,R, R R 2 BOX 81 LOGANSPOET 46947	IM	030	HOWLAND,CARL,BRUCE, BOX 506 GREEN ACRES CRAWFORDSVILLE 47933	GP	198
OROWITZ,MARCEL,IRWIN, 6111 HARRISON ST MERRILLVILLE 46410	U	174	HOYT,LESTER,HAROLD, METHODIST HOSP INDIANAPOLIS 46202	PTH	134
ORST,WM,NICHOLAS, 123 N COURT ST CROWN POINT 46307	GP	174	HOYT,MILLARD,L, 5614 E 21ST ST INDIANAPOLIS 46218	P	134
ORSWELL,RICHARD,GLENN, BRISTOL 46507	IM	070	HTAIN,MIN, 221 S 6TH ST TERRE HAUTE 47801	K	298
ORSWELL,RICHARD,R, 2600 GREENBUSH LAFAYETTE 47904	IM	286	HUBBARD,JESSE,D, 1100 W MICHIGAN ST INDIANAPOLIS 46207	PTH	134
ORVATH,GEO,ALEXANDER, 211 N EDDY ST SOUTH BEND 46617	PD	258	HUBER,RICHARD,GLEN, 219 SYCAMORE DR BEDFORD 47421	FP	182
ORWITZ,THOMAS, 5402 N MERIDIAN INDIANAPOLIS 46208	URS	134	HUGGINS,VICTOR,SPENCER, 611 HARRIETT AVE EVANSVILLE 47710	OBG	296
OSTETTER,MICHAEL,G, 3266 NORTH MERIDIAN ST INDIANAPOLIS 46208	U	134	HUGHES,ANSON,F, 2600 GREENBUSH ST LAFAYETTE 47904	OBG	286
OUCK,RICHARD,JAMES, P O BOX 556 BEVERLY SHORES 46301	OPH	178	HUGHES,CHAS,EDGAR, 5626 E 16TH ST INDIANAPOLIS 46218	PS	134
OUUSER,DEWARD,S, 515 NORTH LAFAYETTE BLVD SOUTH BEND 46601	OBG	258	HUGHES,RICHARD,R, 908 CARROLTON BLVD WEST LAFAYETTE 47906	EM	286
OUUSER,KEIM,THOS, 515 NORTH LAFAYETTE SOUTH BEND 46601	OBG	258	HUGHES,WM,BRADLEY, WATERLOO 46793	GP	058
OUSTON,FRED,DURMENT, 30 W HIGH ST LAWRENCEBURG 47025	GP	050	HUI,HANNAH,MAY-TUK, 1512 14TH STREET BEDFORD 47421	PTH	182
OVANESSIAN,RAFFY,A, 7863 BROADWAY MERRILLVILLE 46410	GE	174	HULL,DE,WAYNE L, 3030 LAKE FORT WAYNE 46805	PS	082
OW,LOUIS,EUGENE, 210 PATTERSON RD LAKEVILLE 46536	GPM	258	HULL,JAMES,EDWARD, ST ELIZABETH MED CTR STE 104 LAFAYETTE 47904	GS	286
HOWARD,JOS,DANL, 2809 HIGH ST LOGANSPOET 46947	FP	030	HULL,JOEL,IRVIN, 6 SHORE DR DUNE ACRES CHESTERTON 46304	GP	230
HOWARD,MARY,JANE, RR 3 BOX 89-17 ZIONSVILLE 46077	CD	134	HUMMEL,RUSSEL,MILLER, 500 WABASH AVE MARION 46952	GP	098
HOWE,FORDYCE,LEE, 2330 BEACON ST FORT WAYNE 46805	GP	082	HUMPHREY,PAUL,EUGENE, 2631 NORTH 9TH ST TERRE HAUTE 47807	U	298
HOWELL,JOS,D, 6525 E 82ND ST-STE 110 INDIANAPOLIS 46250	A	134	HUMPHREYS,JOE,E, 1516 N 2D ST VINCENNES 47591	GP	162

HUMPHREYS, JOHN, LESLIE, 55 HIGHLAND RD APT 202 BETHEL PARK PA 15102	OS	082	HUSSAIN, MOHAMMED, 207 SPARKS AVE JEFFERSONVILLE 47130	CD	03
HUNSBERGER, DONALD, WAYNE, 117 W HIGH ST MONTPELIER 47359	GP	062	HUSSEY, LAWRENCE, KENT, 531 NORTH MAIN ST SOUTH BEND 46601	PTH	25
HUNSBERGER, WALTER, G, 2600 GREENBUSH ST LAFAYETTE 47904	R	286	HUSTED, ROBT, G, 7905 CALUMET AVE MUNSTER 46321	GP	17
HUNT, EDGAR, JOHN, R R 22 BOX 294 TERRE HAUTE 47802	OS	298	HUTSON, RICHARD, ALLEN, 1815 N CAPITOL AVE INDIANAPOLIS 46202	ORS	13
HUNT, JAMES, ANDREW, 5454 N ILLINOIS ST INDIANAPOLIS 46208	P	134	HUUS, JOHN, CHRISTIAN, 421 CHESTNUT ST EVANSVILLE 47713	U	29
HUNT, ROBERT, N, 211 NORTH EDDY STREET SOUTH BEND 46617	IM	258	HYDE, CARROLL, C, 1521 E COLFAX AVE SOUTH BEND 46617	U	25
HUNTEMAN, ROY, KEITH, R R 3 BOX 308A JOHNS ISLAND SC 29455	FP	134			
HUNTER, CHAS, A, IND UNIV MED CTR DEPT OBG INDIANAPOLIS 46202	OBG	134	IGNACIO, OLEGARIO, J, 207 SPARKS AVENUE JEFFERSONVILLE 47130	N	034
HUNTER, DEAN, MURRAY, 316 N SALISBURY WEST LAFAYETTE 47906	OBG	286	ILLMAN, DWAIN, CLARK, 511 TURTLEBACK CREEK ROAD ELLETTSVILLE 47429	EM	214
HUNTER, DONN, R, 843 MAPLE DR GREENFIELD 46140	FP	110	IMHOF, JOS, D, 320 W ADAMS MUNCIE 47305	DR	062
HUONI, JOHN, SIMEON, 1405 YOUNGSTOWN SHOPPING CTR JEFFERSONVILLE 47130	GP	034	IMPERIAL, BORIS, S, 1024 S 6TH ST MEDICAL ARTS BLD TERRE HAUTE 47807	P	298
HURLEY, JAMES, W, ELKHART CLINIC BOX 2507 ELKHART 46514	GE	070	INGRAM, RICHARD, GENE, 206 S MAIN MONTPELIER 47359	GP	062
HURLEY, JOHN, RAWLINS, BOX 545 DALEVILLE 47334	GP	062	INGWELL, GUY, BERNARD, 1520 SOUTH HEATON ST KNOX 46534	FP	274
HURT, LAVERNE, B, 3102 PALM DR DELRAY BEACH FL 33444	OS	134	INLOW, PAUL, MARTYN, 103 W WASHINGTON ST SHELBYVILLE 46176	R	266
HURWITZ, ROBT, MORRIS, 8402 HARCOURT RD INDIANAPOLIS 46260	D	134	INLOW, ROBT, PIERSON, 103 W WASHINGTON SHELBYVILLE 46176	GS	266
HURWITZ, ROGER, ALLEN, I U MEDICAL CENTER INDIANAPOLIS 46202	PDC	134	INLOW, WM, D, 1072 ALTO ROAD LAKE WORTH FL 33460	GS	266
HUSE, PATRICIA, GAIL H, 3500 LAFAYETTE RD STE 301 INDIANAPOLIS 46222	PD	134	IRICK, NEIL, EDWIN, 155 WEST HAMPTON DR INDIANAPOLIS 46208	IM	318
HUSE, WM, MURRAY, 7402 HAZELWOOD AVE INDIANAPOLIS 46260	OBG	134	IRIGOYEN, DAVID, ERNEST, 1919 STATE ST STE 321 NEW ALBANY 47150	P	078

RMSCHER,GEO,W, 3411 N ANTHONY BLVD FORT WAYNE 46805	GS	082	JACOBS,E,ROBERT, R R 6 GRANDVIEW COLUMBUS 47201	GS	014
RMSCHER,JANE,MC MULLEN, 2040 FLORIDA DR FORT WAYNE 46805	PD	082	JACOBSON,WM, ST ELIZABETH HOSP 1501 HARTFORD ST LAFAYETTE 47904	PTH	286
RVINE,WILLIAM,O, 1815 N CAPITOL-STE 610 INDIANAPOLIS 46202	ORS	134	JACQMAIN,RALPH,JOS, 621 S 7TH ST VINCENNES 47591	GP	162
RWIN,GERALD,PORT, R R NO 4 BOX 221 ALEXANDRIA 46001	GP	186	JAHNS,ALBIN,A, VALPARAISO ORTHOPEDIC CLINIC 2501 CUMBERLAND DR VALPARAISO 46383	ORS	230
RWIN,PHYLLIS,R, BACH CHRISTIAN HOSPITAL QALANDARABAD HAZARA PAKISTAN 60704	GP	134	JAMES,CHAS,EDWARD, 7780 N MICHIGAN INDIANAPOLIS 46268	GP	134
SCH,JOHN,HARRY, 8402 HARCOURT RD INDIANAPOLIS 46260	TS	134	JAMES,THOS, 202 PUB BLDG HUNTINGTON 46750	GS	130
SENBARGER,KARL, 111 E 75TH INDIANAPOLIS 46240	GP	134	JANICKI,DAVID,JOHN, 221 SOUTH SIXTH ST TERRE HAUTE 47807	IM	298
SENBURG,PAUL,DAVID, 5626 E 16TH INDIANAPOLIS 46218	PD	134	JANKOWSKI,ERNEST,BERNARD, 411 S SHERIDAN ST SOUTH BEND 46619	GP	258
SKE,PAUL,GEO, 818 E 79TH ST INDIANAPOLIS 46240	IM	134	JAO,RODOLFO,L, 295 SOUTH WISCONSIN HOBART 46342	ID	174
VERSION,ROBERT,LOUIS, 4134 NORTH ILLINOIS INDIANAPOLIS 46208		134	JAOJOCO,ARMANDO,E, P O DRAWER H BATESVILLE 47006	FP	250
VY,JOHN,H, ELKHART CLINIC BOX 2507 ELKHART 46514	IM	070	JARDENIL,ROMULO,S, KENTLAND 47951	GP	204
			JARDINE,DON,ROSS, 3500 LAFAYETTE RD INDIANAPOLIS 46222	ORS	134
JACKSON,DEAN,B, CAMERON MEM HOSP DEPT GP ANGOLA 46703	GP	278	JARRETT,JOHN,CROW, 702 RIVER DR MARION 46952	OBG	098
JACKSON,HOWARD,CLAY, 104 E 3RD ST MADISON 47250	GP	150	JARRETT,PAUL,EUGENE, 1415 RAIBLE AVE ANDERSON 46011	OBG	186
JACKSON,JAMES,WOODROW, 2828 FAIRFIELD AVE FORT WAYNE 46807	CD	082	JARRETT,PAUL,EUGENE, 8330 NAAB ROAD INDIANAPOLIS 46260	OBG	134
JACKSON,JOHN,F, 5315 CLOVERBROOK DR FORT WAYNE 46806	AN	082	JAY,ARTHUR,CARL, R R 1 BOX 387 PARKER 47368	PTH	062
JACKSON,ROBT,FRANKLIN, PROFESSIONAL ARTS BLDG MARION 46952	GS	098	JAY,ARTHUR,NOTTINGHAM, RR1 BOX 107B NINEVEH 46164	OM	134
JACOBO,MIGUEL,JAIME, 1419 CARROLL ST EAST CHICAGO 46312	GP	174	JAY,JAMES,MILTON, 1645 HALL PL INDIANAPOLIS 46202	IM	134

JAY,STEPHEN,J, WISHARD MEMORIAL HOSPITAL INDIANAPOLIS 46202	IM	134	JOHN,MAURICE,EDWARD, 207 SPARKS AVE NO 306 JEFFERSONVILLE 47130	UPH	034
JEAN,THOS,A, MORRISTOWN 46161	GP	266	JOHNLOZ,DAVID,KEITH, 3434 HOMESTEAD DR BLOOMINGTON 47401	IM	214
JEHANYAR,MOHAMED,ALI, P O BOX 614 MONTICELLO 47960	GP	322	JOHNS,JANET,SUSAN, 3510 WOODCLIFF LAFAYETTE 47905	GP	286
JENKINS,JOHN,EDWARD, 3740 N CENTRAL INDIANAPOLIS 46208	GP	134	JOHNSON,ALBERT,C, 1815 N CAPITOL ST INDIANAPOLIS 46202	GS	134
JENKINS,JOHN,L, 919 EAST JEFFERSON BLVD SOUTH BEND 46622	CO	258	JOHNSON,CHAS,WM, 1802 NORTH ILLINOIS ST INDIANAPOLIS 46204	OTO	134
JENKINS,ROBT,EUGENE, 3500 LAFAYETTE RD STE 104 INDIANAPOLIS 46222	C	134	JOHNSON,EARL,HUNT, 4801 PLANTATION DR INDIANAPOLIS 46250	U	134
JENSEN,JAMES,WALDEMAR, 1511 WABASH MICHIGAN CITY 46360	OBG	178	JOHNSON,EDWARD,M, 30-A BALTZELL GATE RD FORT MC CLELLAN AL 36205	OBG	298
JENSEN,ROBT,EUGENE, 102 MEDICAL CENTER BLDG FORT WAYNE 46802	OTO	082	JOHNSON,FRANCIS,NEAL, METHODIST HOSPITAL 600 GRANT ST GARY 46402	AN	174
JESCH,DORIS,ANN, 706 GARDNER MARION 46952	PD	098	JOHNSON,FRANK, 2948 KESSLER BLVD N DRIVE INDIANAPOLIS 46222	OBG	134
JESSEPH,JOHN,ERVIN, 1100 W MICHIGAN ST INDIANAPOLIS 46202	GS	134	JOHNSON,GEO,MARTIN, 1250 CHESTER BLVD RICHMOND 47374	GS	314
JETT,CLYDE,W, 18 W NATIONAL AVE SEELYVILLE 47878	GP	298	JOHNSON,HAROLD,VICTOR, 2301 W MICHIGAN ST EVANSVILLE 47712	GP	296
JEWELL,GEO,MONROE, 610 ARMSTRONG KOKOMO 46901	A	126	JOHNSON,HERBERT,S, 2600 GREENBUSH LAFAYETTE 47904	GS	286
JEWETT,JOE,HAINES, 3120 N MERIDIAN ST INDIANAPOLIS 46208	IM	134	JOHNSON,JAMES,BASHFORD, 600 N ARLINGTON GREENCASTLE 46135	FP	242
JIBILIAN,ARTIN,YACOB, 220 SHERLAND BLDG SOUTH BEND 46601	U	258	JOHNSON,PAUL,DEWEY, 822 N 15TH ST TERRE HAUTE 47807	GS	298
JIMENEZ,FELICIANO,F, 800 MC ARTHUR NO 22 MUNSTER 46321	IM	174	JOHNSON,PHILIP,JAMES, 5110 N CLINTON ST FORT WAYNE 46825	FP	082
JIMENEZ,PEDRO,L, 727 MARTHA AVE JEFFERSONVILLE 47130	AN	034	JOHNSON,ROBT,DONALD, 722 W MAIN ST MADISON 47250	GP	150
JINNINGS,LOREN,EARL, P O BOX R R 3 AUBURN 46706	GP	058	JOHNSON,STEPHEN,LEE, 611 HARRIETT SUITE 202 EVANSVILLE 47710	IM	296
JOBES,JAMES,EPLY, 54 MONUMENT CIRCLE INDIANAPOLIS 46204	OM	134	JOHNSON,THOS,WILSON, 1802 N ILLINOIS ST INDIANAPOLIS 46202	UTO	134

JOHNSON, WALLACE, D, 2900 W 16TH ST BEDFORD 47421	GE	182	JONES, RANDOLPH, 2416 N CAPITOL INDIANAPOLIS 46208	OBG	134
JOHNSON, WM, VERNON, 1919 STATE ST NEW ALBANY 47150	R	078	JONES, RICHARD, ALLEN, 8402 N HARCOURT RD STE 208 INDIANAPOLIS 46260	OTO	134
JOHNSTON, GERALD, P, 1575 NORTHWESTERN AVE INDIANAPOLIS 46202	P	134	JONES, ROBT, B, 1528 W FRANK ELKHART 46514	OTO	070
JOHNSTON, RICHARD, M, 9962 DIEBOLD RD FORT WAYNE 46825	AN	082	JONES, THOS, MORRIS, 2580 CHARLESTOWN ROAD NEW ALBANY 47150	OTO	078
JOHNSTON, ROBT, L, 809 RIVERSIDE DRIVE MELBOURNE FL 32951	GE	318	JONES, WM, HOWARD, 1630 SOUTH OHIO MARTINSVILLE 46151	GP	202
JOHNSTONE, DOUGLAS, F, 2020 W 86TH STREET INDIANAPOLIS 46260	IM	134	JONTZ, JOE, GORDON, 3124 E STATE BLVD FORT WAYNE 46805	GS	082
JOHLY, WALTER, WM, 8402 HARCOURT RD INDIANAPOLIS 46260	TS	134	JONTZ, JON, PHILLIP, WINDRIDGE OFFICE BLDG SUITE 115 5435 EMERSON WAY NORTH INDIANAPOLIS 46226	AN	134
JOHLY, WESLEY, PARVIN, 711 MAPLE RICHLAND 47634	GP	270	JONTZ, RICHARD, LEE, 2200 LAKE AVE SUITE 150 FORT WAYNE 46805	R	082
JOHNS, ALLEN, WM, 6060 N COLLEGE AVE INDIANAPOLIS 46220	IM	134	JORDAN, RICHARD, ALLEN, HARRISON DR CORYDON 47112	FP	114
JOHNS, ANABEL, RATCLIFF, 3301 CEDAR LANE LAFAYETTE 47904	AN	286	JOSEPH, REX, MORRIS, 1500 ALBANY BEECH GROVE 46107	FP	134
JOHNS, DAVID, ERVAN, 320 N MERIDIAN ST INDIANAPOLIS 46204	OTO	134	JOSEPHSON, DAVID, ALAN, 10915 LAKEVIEW DR CARMEL 46032	N	134
JOHNS, DAVID, GEO, 1504 N MADISON ANDERSON 46011	GP	186	JOSHI, PRAKASH, NARAYAN, 500 WABASH AVE MARION 46952	IM	098
JOHNS, FRANCIS, PAUL, 745 N RILEY AVE INDIANAPOLIS 46201	AN	134	JOSLIN, GEO, DAVID, 900 EAST STATE BLVD FORT WAYNE 46805	P	082
JOHNS, FREDERICK, HAVEN, 960 LOCKE ST NEUROLOGY DEPARTMENT INDIANAPOLIS 46202	N	134	JOYNER, JOHN, ERWIN, 3901 N MERIDIAN ST NO 336 INDIANAPOLIS 46205	NS	134
JOHNS, GORDON, CHAS, 6360 BRANSHAW RD INDIANAPOLIS 46220	GP	134	JUDD, RUSSELL, LLOYD, 1213 N ARLINGTON INDIANAPOLIS 46219	U	134
JOHNS, JOHN, CARL, 1201 MICHIGAN AVE STE B LOGANSPOET 46947	PD	030	JUERGENS, RICHARD, BOWMAN, 1724 PRAIRIE LANE FORT WAYNE 46808	GP	082
JOHNS, JOHN, DAVID, 1719 NORTH MADISON AVE ANDERSON 46012	OPH	186	JURGENSEN, WALTER, T, 3610 BROOKLYN AVE FORT WAYNE 46807	GP	082
JOHNS, KING, SOLOMON, P O BOX 383 MICHIGAN CITY 46360	GP	178	JUSTIN, RENATE, G, 1024 S 6TH TERRE HAUTE 47807	GP	298

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KADERABEK, DONAL, JOS, 1611 25TH STREET SUITE B BEDFORD 47421	GS	182	KARNAPFEL, EUGENE, THADDEUS, LOGANSPOUT STATE HLSP LOGANSPOUT 46947	P	030
KAHLER, MAURICE, V, 2638 KESSLER BLVD N DR INDIANAPOLIS 46222	GP	134	KAROL, HERBERT, JAY, SUITE 103 3-RIVERS E FORT WAYNE 46802	U	082
KAHN, ALEXANDER, JEROME, 8402 HARCOURT RD 406 INDIANAPOLIS 46260	PD	134	KATTERJOHN, JAMES, CECIL, 9035 PICKWICK DR INDIANAPOLIS 46260	FR	134
KAHN, HOWARD, L, 8402 HARCOURT RD INDIANAPOLIS 46260	OBG	134	KAUFFMAN, HARLEY, MARLEY, 5607 NEWBURG RD EVANSVILLE 47715	P	296
KAISER, JAMES, L, 5626 EAST 16TH ST NO 13 INDIANAPOLIS 46218	OKS	134	KAUFMAN, ALAN, 30 DOUGLAS ST HAMMOND 46324	NS	174
KALKER, MORTON, 704 GREENBRIAR RD MUNCIE 47304	AN	062	KAUFMAN, JULIAN, ROWE, 3030 LAKE AVE FORT WAYNE 46805	A	082
KALSBECK, JOHN, E, 1100 W MICHIGAN AVE INDIANAPOLIS 46202	NS	134	KAY, JOHN, BOYD, MEDICAL ARTS BLDG 1255 ENGLE ST HUNTINGTON 46750	FP	130
KAMEN, JACK, M, 540 TYLER ST GARY 46402	AN	174	KAYS, HOWARD, W, 1751 DIANNE AVE EVANSVILLE 47715	FP	296
KAMMEN, LEU, 3202 W 16TH ST INDIANAPOLIS 46222	GP	134	KEATING, JOHN, URICH, 8415 WASHINGTON BLVD INDIANAPOLIS 46240	P	134
KAMMER, GRACE, E CLEM, 420 W WASHINGTON ST MUNCIE 47305	IM	062	KEBEL, ARTHUR, PAUL, 4411 N MERIDIAN INDIANAPOLIS 46208	OM	134
KAMMEYER, WM, ALLEN, 3217 LAKE AVE FORT WAYNE 46805	FP	082	KECK, CARLETON, ALLEN, 2828 FAIRFIELD AVE FORT WAYNE 46807	OPH	082
KANDUL, THOS, STANLEY, 3700 WASHINGTON AVE EVANSVILLE 47750	PTH	296	KEELING, FORREST, E, 615 W WALNUT PORTLAND 47371	PD	146
KANE, JACK, LEE, 50 EAST 91ST STREET INDIANAPOLIS 46240	OPH	134	KEENAN, GEO, BRYAN, 3225 SHELBY AVE INDIANAPOLIS 46227	FP	134
KANTZER, FLOYD, BERNHARD, 12436 MORROW AVE N E ALBUQUERQUE NM 87112	GP	058	KEENAN, PATRICK, JUSTIN, 211 N EDDY ST SOUTH BEND 46617	N	258
KAPOOR, GURBACHAN, SINGH, 6829 PIERCE MERRILLVILLE 46410	R	174	KEENER, GERALD, THERON, 5508 EAST 16TH ST INDIANAPOLIS 46219	OPH	134
KARBERG, RICHARD, JOHN, 2400 FERRY ST LAFAYETTE 47904	OBG	286	KEFFER, HARRY, LEE, UNION HOSPITAL TERRE HAUTE 47808	AN	298
KARN, JOHN, W, 1535 WALL ST SOUTH BEND 46615	AN	258	KELLAMS, JEFFREY, JEROME, 8210 SOUTH MADISON AVE INDIANAPOLIS 46227	P	134
			KELLAR, PHILIP, ERNEST, 904 W RIDGE RD HOBART 46342	GP	174

ELLEY, JACK, LESLIE, 2600 GREENBUSH ST LAFAYETTE 47904	GS	286	KENT, RICHARD, NELSON, 327 MED CTR BLDG FORT WAYNE 46802	IM	082
ELLEY, WM, EDWARD, 5626 EAST 16TH INDIANAPOLIS 46218	FP	134	KENYON, CHAS, EMIL, 8 S GREEN ST CAMBRIDGE CITY 47327	GP	314
ELLY, GEO, GREGORY, 7905 CALUMET AVE MUNSTER 46321	GS	174	KEOUGH, THOS, FRANCIS, 600 E WINONA AVE WARSAW 46580	CD	166
ELSEY, JUDITH, ANN, 7905 CALUMET MUNSTER 46321	DR	174	KEPHART, STEWART, BRUCE, 303 S MAIN ST BLUFFTON 46714	OBG	318
ELSEY, ROBT, MOFFAT, 1200 MICHIGAN AVE LA PORTE 46350	GP	178	KEPLER, ROBT, WENDEL, OSMIC PLACE LA PORTE 46350	GP	178
EMKER, BERNARD, PERKINS, MED ARTS BLDG 721 W 13TH ST JASPER 47546	GS	066	KEPLINGER, JAMES, ELLIS, 1000 NORTH 14TH ST LAFAYETTE 47904	NS	286
EMP, JOHN, THEODORE, 122 E 7TH ST MICHIGAN CITY 46360	GP	178	KEPNER, ROBT, STANLEY, 1431 N MADISON AVE ANDERSON 46012	PD	166
EMPF, GERALD, FIDELIS, 3032 SEARS RD SPRING VALLEY OH 45370	IM	218	KERLIN, JOS, C, 100 MEADOW DR DANVILLE 46122	GP	116
EMPLER, NORMAN, ALAN, 3124 EAST STATE BLVD FORT WAYNE 46805	OPH	082	KERN, CLARENCE, GERALD, 1720 N LEBANON ST LEBANON 46052	GP	022
ENDALL, FOREST, MACK, 654 WOODLAND CT NAPPANEE 46550	EM	070	KERNEK, CLYDE, B, 8402 HARCOURT RD INDIANAPOLIS 46260	ORS	134
ENDRICK, FRANK, JENNESS, 2000 SO 15TH ST OAK COURT C 1-2 GOSHEN 46526	D	174	KERR, DONALD, MILTON, 2900 W 16TH ST BEDFORD 47421	GP	182
ENDRICK, WM, M, 1201 HADLEY RD NW MOORESVILLE 46158	U	202	KERRIGAN, JOHN, FRANCIS, 916 WASHINGTON ST MICHIGAN CITY 46360	GS	178
ENLEY, DAVID, JOHN, 614 S RANGELINE RD CARMEL 46032	OBG	134	KERRIGAN, ROBT, LEE, 916 WASHINGTON ST MICHIGAN CITY 46360	GP	178
ENNEDY, HUNTER, FELIX, 5026B ALLISONVILLE ROAD INDIANAPOLIS 46205	GP	134	KERRIGAN, WM, F, PROF ARTS BLDG CONNERSVILLE 47331	AN	074
ENNEDY, JOS, T, 5316 BRENDONRIDGE RD INDIANAPOLIS 46226	AN	134	KERSHNER, CHARLES, R, 707 RIVER DR MARION 46952	ORS	098
ENNEDY, MICHAEL, WM, 495 WESTFIELD RD NOBLESVILLE 46060	GS	106	KESIM, MUFIT, HUSAM, 1332 W INDIANA AVE ELKHART 46514	PD	070
ENNEY, DAVID, BERNARD, 5506 E 16TH ST SUITE 13 INDIANAPOLIS 46218	OPH	134	KESSLER, ROBT, B, 611 HARRIET RM 305 EVANSVILLE 47710	GP	296
			KETTELKAMP, DONALD, B, 1100 WEST MICHIGAN ST INDIANAPOLIS 46202	ORS	134

KEYES, ROBT, C, 131 E TILLMAN RD FORT WAYNE 46806	PD	082	KIM, JOON, SUN, LA PORTE HOSP LA PORTE 46350	PTH	17
KHAIRI, MUHAMMAD, R ABUL, IV MEDICAL CENTER 1100 W MICHIGAN INDIANAPOLIS 46202	END	134	KIM, KIL, CHOL, INDIANA UNIV MED CTR INDIANAPOLIS 46202	AN	13
KHALOUF, HERBERT, CHAS, 1251 W KEM ROAD MARION 46952	GS	098	KIM, MU, SHIN, ST MARGARET HOSP 25 DOUGLAS ST HAMMOND 46320		17
KHALOUF, SHIRLEY, THOMPSON, 1204 OVERLOOK DR MARION 46952	PM	098	KIM, SUNG, SOO, 6110 MANCHESTER DR FORT WAYNE 46815	GS	08
KHATON, ODESSA, M, 514 E 86TH ST GARY 46410	P	174	KIM, YOUNG, ROCK, 6111 HARRISON ST MERKILLVILLE 46410	OBG	17
KHO, EUSEBIO, C, 137 E MC CLAIN AVE SCOTTSBURG 47170	GS	262	KIMBROUGH, ROBERT, F, 2730 E STATE BLVD FORT WAYNE 46805	ORS	08
KHO, JAUW, BIE, 17 RUTLEDGE PL TERRE HAUTE 47803	PTH	296	KIMMEL, GEO, EDWARD, 458 MARTINS LANE EVANSVILLE 47715	AN	29
KIECHLE, FREDERICK, L, R R 4 BOX 309 NO 3 SCHOOL ROAD EVANSVILLE 47712	PTH	296	KIMMEL, LOUIS, EDMUND, R R 4 190 D VALPARAISO 46383	GS	23
KIGHT, JERRY, LEE, 1947 PIN OAK COURT INDIANAPOLIS 46260	DR	134	KINCAID, RAYMOND, KEITH, 202 S WEST ST TIPTON 46072	GP	29
KILGORE, BYRON, W, 106 THREE RIVERS EAST FORT WAYNE 46802	P	082	KINCAID, ROBT, STEPHEN, 7117 E CHERRY EVANSVILLE 47715	AN	29
KILLEN, LARRY, FAY, 5785 N DELAWARE INDIANAPOLIS 46220	DR	134	KINDELL, HURSCHELL, D, 108 E WASHINGTON ST NEW RICHMOND 47967	GP	19
KILMER, WARREN, L, 2674 P PORTAGE MALL PORTAGE 46368	GS	230	KING, CHAS, ROSS, 1415 RAIBLE AVE ANDERSON 46011	GP	18
KIM, BUM, JOO, 513 NORTH MICHIGAN ST SOUTH BEND 46601	OBG	258	KING, FRANK, KARL, 605 MARSHA CT KOKOMO 46901	EM	12
KIM, CHINSOO, WHANG, 2450 169TH ST HAMMOND 46323	PD	174	KING, HAROLD, 1100 W MICHIGAN ST INDIANAPOLIS 46202	TS	13
KIM, CHONG-BIN, 3200 SYCAMORE CT SUITE 2-A COLUMBUS 47201	PD	014	KING, JAY, M, 812 NORTH LOGANSPOET 46947	GS	03
KIM, CHONG, SOO, 2210 S E BROWNING RD EVANSVILLE 47711	AN	302	KING, JOHN, THOMAS, 8127 MERRILLVILLE ROAD MERRILLVILLE 46410	OBG	17
KIM, HWA, WOONG, 1843 43RD DR TERRE HAUTE 47802	AN	298	KING, JOS, P, 3231 NORTH MERIDIAN ST NO 21 INDIANAPOLIS 46208	P	13
KIM, I, YOUNG DAI, 1539 NE 143RD SEATTLE WA 98125	GS	134	KING, LEROY, HARRY, 5470 E 16TH NO9 INDIANAPOLIS 46218	NEP	13

ING, MICHAEL, STEVEN, 5626 E 16TH ST INDIANAPOLIS 46218	OBG	134	KISSINGER, KNIGHT, L, 411 E GILMORE ST ANGOLA 46703	GP	278
ING, ROBT, D, I U MEDICAL CENTER INDIANAPOLIS 46202	TS	134	KITT, WALTER, 7550 HOHMAN AVE MUNSTER 46321	P	174
ING, ROBT, PRESTON, 17615 STATE RD 23 SOUTH BEND 46635	FP	258	KLAIN, BENJ, V, 4157 N COLLEGE AVE INDIANAPOLIS 46205	GP	134
ING, ROBT, W, 13301 LINCOLN PLAZA CEDAR LAKE 46303	GP	174	KLAMER, CHAS, H, 715 MAC ARTHUR ST JASPER 47546	GP	066
INGMA, ROY, ELMER, DEMOTTE CLINIC DEMOTTE 46310	GP	230	KLASSEN, OTTO, DYCK, P O BOX 6 OAKLAWN PSY CENTER ELKHART 46514	CHP	070
INGSBURY, DAVID, HOMER, 2020 W 86TH ST RD 106 INDIANAPOLIS 46260	D	134	KLATCH, BEN, Z, 1501 HARTFORD ST LAFAYETTE 47904	IM	286
INKADE, PAUL, TERRENCE, 1015 BROAD ST NEW CASTLE 47362	GS	122	KLAUS, JULIUS, W, PURDUE UNIV STUDENT HEALTH WEST LAFAYETTE 47906	P	286
INMAN, PHILLIP, BRAMMER, 609 DUBOIS ST VINCENNES 47591	ORS	162	KLEIFGEN, WM, A, 446 W PONTIAC ST FORT WAYNE 46807	GP	082
INO, YOICHI, 540 TYLER ST GARY 46402	PTH	174	KLEIN, JOHNNY, CARL, 740 E 52D ST INDIANAPOLIS 46205	ORS	134
INTNER, BURTON, E, 236 SIMPSON ST ELKHART 46514		070	KLEIT, STUART, ALLEN, INDIANA UNIV MED CTR INDIANAPOLIS 46202	NEP	134
IRACOFE, GEO, ROELAND, 1350 CHESTER BLVD RICHMOND 47374	GP	314	KLEOPFER, RONALD, G, 5050 N CLINTON ST FORT WAYNE 46825	ORS	082
IRBY, TED, C, P O BOX 707 GREENFIELD 46140	GP	110	KLEPINGER, HARRY, EDWIN, 909 NORTH 21ST ST LAFAYETTE 47904	GP	286
IRKHOFF, PAUL, JOS, 5430 E 21ST ST INDIANAPOLIS 46218	PD	134	KMAK, CHESTER, JOHN, 420 EAST 86TH AVE MERRILLVILLE 46410	OBG	174
IRSHMAN, FORREST, EARL, 41 BRIAR RD MUNCIE 47304	GP	062	KNIGHT, ERNEST, LARRY, ELKHART CLINIC BOX 2507 ELKHART 46514	END	070
IRTLEY, JAMES, MARION, GREEN ACRES BOX 506 CRAWFORDSVILLE 47933	OBG	198	KNIGHT, LEWIS, W, 3124 E STATE ST FORT WAYNE 46805	OBG	082
IRTLEY, ROBT, WAYNE, 350 URBAN ST DANVILLE 46122	GP	118	KNOCH, WAYNE, LEE, 3515 PINE NEEDLE PLACE WEST LAFAYETTE 47906	GP	090
IRTLEY, WM, R, 7447 N PARK AVE INDIANAPOLIS 46240	IM	134	KNODE, KENNETH, THOMSON, 406 SHERLAND BLDG SOUTH BEND 46601	A	258
ISSEL, WESLEY, ALLEN, 1815 N CAPITOL INDIANAPOLIS 46202	P	134			

KNOTE, JOHN, ALTON, RADIOLOGY DEPT HOME HOSPITAL LAFAYETTE 47904	R	286	KOONTZ, JAMES, ARTHUR, 2009 JACKSON DR VINCENNES 47591	P	162
KNOTTS, SLATER, LAKE AND FOREST CLUB BROWNSTOWN 47220	R	138	KOONTZ, WM, ALFRED, 334 E MAIN ST GAS CITY 46933	GP	098
KO, RICHARD, CHOON BONG, P O 87 GASTON 47342	GP	062	KOPCHA, JOS, EDWARDS, 504 BROADWAY GARY 46402	OBG	17
KOBAK, ALFRED, JULIAN, 1101 E GLENDALE BLVD VALPARAISO 46383	OBG	230	KOPECKY, ROBT, RAY, 4131 SHELBY ST INDIANAPOLIS 46227	OBG	13
KOBRIN, MEYER, WALTER, 3229 BROADWAY GARY 46408	GP	174	KOPP, WM, R, 2101 JACKSON ST STE 105 ANDERSON 46014	GS	18
KOCH, EDWIN, FERDINAND, 2401 UNIVERSITY AVE MUNCIE 47303	R	062	KORN, ALLAN, MICHAEL, 801 ST MARYS DR EVANSVILLE 47715	IM	29
KOCH, ELMER, L, 201 E COLUMBIA ST DANVILLE 46122	GP	118	KORN, JEROME, MARTIN, 3290 GRANT ST GARY 46408	GP	17
KOCH, HOWARD, W, 700 BROWN ST WINCHESTER 47394	GP	246	KORNAFEL, LADDIE, HENRY, 5626 E 16TH INDIANAPOLIS 46218	GS	13
KOENIG, ROBT, LOUIS, 1101 GLENDALE VALPARAISO 46383	FP	230	KOSS, KENNETH, WM, 1600 W JACKSON ST MUNCIE 47303	FP	06
KOHLSTAEDT, KARL, C, 8685 GUILFORD AVE INDIANAPOLIS 46240	UM	134	KOURANY, EDGAR, 1125 N INDIANA AVE MOORESVILLE 46158	FP	13
KOHLSTAEDT, KENNETH, G, 645 80TH ST INDIANAPOLIS 46240	GS	134	KOURANY, OSCAR, 1125 N INDIANA AVE MOORESVILLE 46158	FP	13
KOHNE, ROBT, WM, 3010 UNDERWOOD ST LAFAYETTE 47904	GP	286	KOVACH, DREW, ANTHONY, 530 N MICHIGAN ARGOS 46501	FP	19
KOLAR, OLDRICH, J, IND UNIV MED CTR 1100 W MICHIGAN ST INDIANAPOLIS 46202	N	134	KOWALSKI, EDGAR, P, 236 SIMPSON ST ELKHART 46514	GS	07
KOLETTIS, JOHN, GEO, 6111 HARRISON ST MERRILLVILLE 46410	GP	174	KRABILL, WILLARD, S, 120 CARTER RD GOSHEN 46526	PH	07
KONKLE, AMY, D MC KAY, 6464 DEAN ROAD INDIANAPOLIS 46220	P	134	KRAFT, BENNETT, 1436 JOHN KINGLEY PKWY SARASOTA FL 33577	A	13
KOOIKER, JOHN, E, N 604 IND UNIV HOSP 1100 NORTH MICHIGAN INDIANAPOLIS 46202	P	134	KRANING, KENNETH, KLAIRE, KRANING CLINIC KEWANNA 46939	GP	09
KOONS, KARL, M, 5470 E 16TH ST INDIANAPOLIS 46218	GS	134	KRAUS, MAURICE, D, ARNETT CLINIC 2600 GREENBUSH ST LAFAYETTE 47904	R	28
			KREITL, DOROTHY, M REEVES, RICHMOND STATE HOSP RICHMOND 47374	P	31

REMERS,GEO,ADAM, 400 S BERKLEY RD STE C KOKOMO 46901	U	126	KUDELE,LOUIS,THOS, 1700 DAVIS AVE WHITING 46394	AN	174
RESLER,LEON,E, 403 NORTH ADE ST KENTLAND 47951	GP	286	KUHN,ARTHUR,J, 7905 CALUMET AVE MUNSTER 46321	OTO	174
RESS,JAMES,WALTER, 912 W MC GALLIARD MUNCIE 47303	GS	062	KUHN,FREDERICK,LEE, P O BOX 6275 SOUTH BEND 46615	CM	258
RIEBLE,W,WMYMOND, 221 S 6TH ST TERRE HAUTE 47801	IM	298	KUHN,ROBT,WOODROW, MAIN ST WILKINSON 46186	FP	110
RIEL,W,WM,B, 5630 W WASHINGTON ST INDIANAPOLIS 46241	GP	134	KUIPERS,FRED,MERRILL, 2600 GREENBUSH ST LAFAYETTE 47904	CD	286
RIZMAN,DAVID,JOHN, 53100 PLACID DR SOUTH BEND 46637	AN	258	KULSAKDINUN,CHAIRAT, 6111 HARRISON ST MERRILLVILLE 46410	PD	174
ROCZEK,STEPHEN,ERIC, 1225 E COOLSPRING MICHIGAN CITY 46360	GPH	178	KUNKLER,ARNOLD,W, 1700 N 7TH ST TERRE HAUTE 47804	GS	298
RSEK,ARCHIE,JOHN, 10 N MICHIGAN ST HOBART 46342	GP	174	KUNKLER,W,CHAS, 1119 SOUTH CENTER ST TERRE HAUTE 47802	GS	248
RUEGER,BARBARA,J JACOBS, 946 N JEFFERSON ST HUNTINGTON 46750	R	130	KUNTZ,HERMAN,W,WM, 5317 E 16TH ST NO 7 INDIANAPOLIS 46218	OTO	134
RUEGER,JOHN,EDWARD, 1146 DUNROBBIN LANE SOUTH BEND 46614	AN	258	KURLANDER,GERALD,JAY, 7917 SPRING MILL ROAD INDIANAPOLIS 46260	R	134
RUEGER,JOHN,EUGENE, 5717 S ANTHONY BLVD FORT WAYNE 46806	GP	082	KURTZ,PHILIP,LOUIS, 296 W 73RD ST INDIANAPOLIS 46260	IM	134
RUEGER,ROBT,B, 2739 CENTRAL AVE COLUMBUS 47201	GP	014	KURTZ,RICHARD, 3351 N MERIDIAN INDIANAPOLIS 46208	OTO	134
RUEGER,THOS,PAUL, 611 HARRIET ST STE 301 EVANSVILLE 47710	NS	296	KURTZ,ROBERT,S, 202 SW ST TIPTON 46072	FP	290
RYSEK,STANLEY,HENRY, 1919 N CAPITOL AVE INDIANAPOLIS 46202	OM	134	KUYKENDALL,GERALD,LEE, 400 EIGHTH AVE TERRE HAUTE 47804	IM	248
RY,MARSHALL,JU-CHUAN, 802 LAPORTE AVE VALPARAISO 46383	PD	230	KWITNY,ISADORE,JACOB, 2206 BOSTON CT NO A INDIANAPOLIS IN 46208	IM	134
UBIK,FRANCIS,JOS, 902 PINE ST MICHIGAN CITY 46360	ABS	178			
			L		
UBLEY,JAMES,DANL, 304 NORTH WALNUT ST PLYMOUTH 46563	FP	190	LA DINE,CLARENCE,B, 5417 N MERIDIAN INDIANAPOLIS 46208	GP	134
UBLEY,JAMES,DUANE, 304 N WALNUT ST PLYMOUTH 46563	GP	190	LA FOLLETTE,FORREST,R, 2450 169TH ST HAMMOND 46323	GP	174

LA FOLLETTE, JAMES, WARREN, 839 AUTO MALL RD BLOOMINGTON 47401	FP	214	LAMB, RUSSELL, WALTER, 3120 N MERIDIAN ST INDIANAPOLIS 46208	OM	134
LA FOLLETTE, ROBT, E, 1000 E SPRING ST NEW ALBANY 47150	GP	078	LAMBER, CHET, KELLER, 400 BOARD OF TRADE BLDG INDIANAPOLIS 46204	GS	134
LA SALLE, RICHARD, MAHLON, 645 N SPRING ST WABASH 46992	FP	302	LAMKIN, EUGENE, HENRY, 1935 N CAPITOL INDIANAPOLIS 46202	IM	13
LA SALLE, ROBT, M, 1025 MANCHESTER AVE WABASH 46992	GP	302	LAMPE, ELFRED, H, 2828 FAIRFIELD AVE FORT WAYNE 46807	OBG	08
LA SALLE, ROBT, MAURICE, 1025 MANCHESTER AVE R R 4 WABASH 46992	GP	302	LAMPTON, LAWRENCE, M, 6311 SUNSET LANE INDIANAPOLIS 46260	PUD	13
LA SALLE, WILLIAM, B, 5050 N CLINTON FORT WAYNE 46805	CRS	082	LANCET, ROBT, OKVILLE, 221 S 6TH TERRE HAUTE 47801	GP	29
LABITAN, CESAR, CANONIGO, ST CATHERINE HOSP EAST CHICAGO 46312	EM	174	LAND, RICHARD, NELSON, 2009 BROWN ST ANDERSON 46014	R	18
LACERA, DONALDO, E, ST MARGARET HOSP DEPT-PTH HAMMOND 46320	PTH	174	LANDIS, CHAS, BYRON, 505 S 7TH ST LAFAYETTE 47901	OM	28
LADIG, DONALD, STEES, 3610 BROOKLYN AVE FORT WAYNE 46807	GP	082	LANDS, ROBT, MASON, 2805 VILLAGE LANE NO 3F VALPARAISO 46383	FP	23
LAHR, RICHARD, E, 1121 WEST THIRD ST MARION 46952	GP	098	LANDWEHR, ALFONS, 5217 LEONE PL INDIANAPOLIS 46226	PUD	13
LAI, EDWARD, MING-CHE, 1505 N 7TH ST P O BOX 1468 TERRE HAUTE 47803	PTH	298	LANE, C, ELAINE LASHLEY, 2840 N HIGH SCHOOL RD SPEEDWAY 46224	IM	134
LAI, NAN, YER, 840 LINCOLNWAY VALPARAISO 46383	OBG	230	LANE, WM, HENRY, 604 N MICHIGAN ST SOUTH BEND 46601	AN	256
LAKER, GENE, CARROLL, 2407 FAIR OAK DR FORT WAYNE 46809	GP	082	LANG, JAY, WM, 5350 E 38TH ST INDIANAPOLIS 46218	AN	134
LAKER, RICHARD, JOHN, 2407 FAIROAK FORT WAYNE 46809	GP	082	LANGSTON, EDWARD, LEE, ST MARYS HOSP DEPT OF F P 3700 WASHINGTON AVE EVANSVILLE 47750	FP	296
LALANI, ABDUL, SULTAN, 6916 W JOHNSON RD LA PORTE 46350	OTO	178	LANMAN, JOHN, U, 716 SEBERGER MUNSTER 46321	IM	174
LAMB, EMMETT, B, 3120 N MERIDIAN ST INDIANAPOLIS 46208	GS	134	LAPP, MICHAEL, ERWIN, 3266 N MERIDIAN INDIANAPOLIS 46208	CD	134
LAMB, FRED, KELLEY, THE ELKHART CLINIC BOX 2507 ELKHART 46514	N	070	LARDIZABAL, JOSE, MARQUEZ, P O BOX 48 BLOOMFIELD 47424	GP	102
			LARGAESPADA, MANUEL, 549 S FLEMING INDIANAPOLIS 46241	GS	134

LARKIN,GREGORY,NEIL, 600 NORTH ARLINGTON ST GREENCASTLE 46135		242	LAWTON,DENIS,FREDERICK, 715 BITTERSWEET MUNCIE 47304	FP	062
LARMORE,JOS,LOWMAN, 612 ANDERSON BANK BLDG ANDERSON 46016	OPH	186	LEAHEY,JEROME,MARTIN, R R 2 UNION CITY 47390	GP	246
LARMORE,ROBERT,HUGHEL, 2828 S FAIRFIELD AVE FORT WAYNE 46807	OPH	082	LEAHY,HOWARD,JOS, P O BOX 150 PENDLETON 46064	GP	186
LARSON,ARTHUR,NORMAN, 1751 N JEFFERSON ST HUNTINGTON 46750	GS	130	LEAK,ROBT,H, BUSWELL 47921	GP	018
LARSON,MICHAEL,S, 7905 CALUMET MUNSTER 46321	P	174	LEATHERMAN,HARTER,L, 1502 E 46TH ST INDIANAPOLIS 46205	OS	134
LASICH,ANTHONY,K, 1815 N CAPITOL AVE INDIANAPOLIS 46202	ORS	134	LEBIODA,HENRY,STANLEY, 230 MORINGSIDE GARY 46408	GP	174
LAUBSCHER,CLARENCE,A, 1201 LAUBSCHER RD EVANSVILLE 47710	GP	296	LEE,DANG-TZUOH, 414 E 86TH ST MERRILLVILLE 46410	DBG	174
LAUDEMAN,WALTER,A, 1515 N A ST ELWOOD 46036	GP	166	LEE,DOMINGO,KING, 3901 S EAST ST INDIANAPOLIS 46227	PM	134
LAUTZ,HERBERT,A, 7905 CALUMET AVE MUNSTER 46321	UTO	174	LEE,GLEN,WARD, 100 N 15TH ST RICHMOND 47374	U	314
LAUTZENHEISER,RICHARD,L, 8330 NAAB ROAD SUITE 313 INDIANAPOLIS 46260	RHU	134	LEE,HYUNG,SOO, 227 S 2ND ST DECATUR 46733	GS	010
LAVELLE,THOS,FRANCIS, 912 EAST LA SALLE AVE SOUTH BEND 46617	PUD	258	LEE,JAMES,C, 465 S 25TH ST TERRE HAUTE 47803	PTH	298
LAW,YU,HONG, R R 6 BOX 220 VALPARAISO 46383	GS	230	LEE,JOHN,W, 5050 N CLINTON FORT WAYNE 46825	ORS	082
LAWLER,GEO,F, 1303 DARTMOUTH DR BRADENTON FL 33507	GP	134	LEE,LORIN,LESLIE, 532 TURTLE CREEK N DRIVE INDIANAPOLIS 46227	DBG	134
LAWLER,JOHN,FIELDING, 421 CHESTNUT ST EVANSVILLE 47713	GS	296	LEE,RICHARD,V, BLOOMINGTON HOSP BOX 1149 BLOOMINGTON 47401	OS	214
LAWRENCE,JAMES,MELTON, 8036 GUNNERY CIR INDIANAPOLIS 46278	GPH	134	LEE,ROBT,YING, 808 E LINCOLNWAY VALPARAISO 46383	GP	230
LAWRENCE,JOSEPH,C, 611 HARRIET ST STE 401 EVANSVILLE 47710	OKS	296	LEFFEL,JAMES,M, R R 3 BOX 111 ZIONSVILLE 46077	GS	134
LAWSON,ALLAN,JOHN, 2020 W 86TH ST INDIANAPOLIS 46260	PD	134	LEFFLER,WM,T, 2141 E 52D ST INDIANAPOLIS 46205	GP	134
LAWSON,LAWRENCE,JOS, 110 NORTH CHERRY ST MUNCIE 47305	GS	062	LEGA,ROBT,EUGENE, 207 SPARKS AVE JEFFERSONVILLE 47130	PD	034

LEHMAN, EVAN, LYNN, 2020 W 86TH ST INDIANAPOLIS 46260	OBG	134	LETT, E, BRISCOE, 404 JOHN F KENNEDY AVE LOGGOSSEE 47553	GP	046
LEHMAN, KENNETH, MAX, TOPEKA 46571	GP	170	LEVATIN, BERNARD, I, 919 E JEFFERSON ST SOUTH BEND 46622	U	258
LEHMANN, DALE, ELBERT, 8830 WHETSTONE RD EVANSVILLE 47711	END	296	LEVI, LEON, 8402 HARCOURT RD INDIANAPOLIS 46260	IM	134
LEHMBERG, OTTO, F C, 118 E VAN BUREN ST COLUMBIA CITY 46725	GP	326	LEVIN, HARVEY, JOS, 2450-169TH ST HAMMOND 46323	GS	174
LEIBUNDGUTH, HENRY, P O BOX 5166 EVANSVILLE 47715	ORS	296	LEWALLEN, STEVEN, ISAAC, 204 LAKEWOOD DR BLOOMINGTON 47401	FP	214
LEINBACH, EARL, R, HAMLET 46532	GP	274	LEWIS, GEO, NORWOOD, 3937 ROLL AVE BLOOMINGTON 47401	IM	214
LEIPHART, CHAS, JOS, 2401 UNIVERSITY AVE MUNCIE 47303	R	062	LEWIS, JAMES, RICHARD, 1200 CHESTER BLVD RICHMOND 47374	IM	314
LEIPOLD, JON, DAVID, 634 NORTH LAFAYETTE SOUTH BEND 46601	P	256	LEWIS, LUCIEN, A, 2200 GRANT ST GARY 46404	PD	174
LEMAN, EUGENE, 6111 HARRISON ST MERRILLVILLE 46410	R	174	LEWIS, PAUL, STANLEY, 6357 ROCKVILLE RD INDIANAPOLIS 46224	GP	134
LEMPKE, LLOYD, WM, 1501 HARTFORD ST STE 1 LAFAYETTE 47904	ORS	286	LEWIS, R, EARL, 2555 DAVIS RD INDIANAPOLIS 46259	OS	134
LENK, GEO, GUSTAVE, 1805 E WASHINGTON BLVD FORT WAYNE 46803	DM	082	LEWIS, ROSA, HILDA, 3648 174TH ST APT 5 A LANSING IL 60438	AN	174
LENTINI, NINO, RUDOLPH, 1524 WASHINGTON ST NEW CASTLE 47362	OKS	122	LEY, GLEN, DAVID, 400 E 3RD ST BLOOMINGTON 47401	IM	214
LENTZ, WM, CHAS, 2828 FAIRFIELD AVE FORT WAYNE 46807	D	082	LEY, LARRY, J, 2009 BROWN ST ANDERSON 46014	U	186
LEON, MARIO, 721 W 13TH ST JASPER 47546	GP	066	LIBBERT, EDWIN, L, 3985 OFFSHORE DR COLUMBUS 47201	R	014
LEONARD, DALE, FORREST, 449 E MAIN ST HAGERSTOWN 47346	GP	314	LIBUNAO, ARTEMIO, SANTOS, RFD-2 VERSAILLES 47042	GP	250
LESER, RALPH, ULRICH, 3901 N MERIDIAN ST INDIANAPOLIS 46208	IM	134	LICHTENBERG, MELVIN, 1717 W 86TH ST INDIANAPOLIS 46260	GP	134
LESHOWER, ALAN, C, 1213 N ARLINGTON INDIANAPOLIS 46219	GS	134	LIDDELL, CHAS, KEALLY, 1225 E COOLSPRING MICHIGAN CITY 46360	GS	178
LESSURE, ALFRED, P, 421 CHESTNUT ST EVANSVILLE 47713	K	296	LIEBSCHUTZ, NORMAN, HELFT, 6450 W 10TH ST SPEEDWAY 46224	PD	134

LIFE,HOMER,LAWRENCE, 7672 COVE TERRACE SARASOTA FL 33581	GS	122	LISS,EMANUEL,C, 119 S EDDY ST SOUTH BEND 46617	D	258
LILAGAN,FLORENTINO,RAMOS, 20606 ARCADEAN DR OLYMPIA FIELDS IL 60461	GS	174	LITTELL,ANDREW,H, 101 COURT ST APT 1400 EVANSVILLE 47715	CLP	296
LIM,NUNILON,CARRANZA, 1823 EAST 8TH ST APT EIN ANDERSON 46012	IM	186	LITTLEFIELD,PAUL,ARTHUR, 1815 N CAPITOL AVE APT 301 INDIANAPOLIS 46202	AN	134
LIMCAGO,OSCAR,GARCIA, 2929 S FIRST ST TERRE HAUTE 47802	NS	298	LITTLEFIELD,SHIRLEY,D, 4040 CROOKED CREEK OVERLOOK INDIANAPOLIS 46208	AN	134
LIN,SHOU-GEM, 6111 HARRISON ST MERRILLVILLE 46410	GS	174	LITZENBERGER,SAM,W, 23 WONSON ST GLOUCESTER MA 01930	U	186
LIND,JAAP,J, 2600 GREENBUSH LAFAYETTE 47901	ORS	286	LIVINGSTON,PETER,HOWARD, 1775 SADDLER DRIVE BEDFORD 47421	U	182
LINDENBORG,PAUL,GUSTAV, 6431 CREEKSIDE LN INDIANAPOLIS 46220	GP	134	LLOYD,FRANK,P, METHODIST HOSP INDIANAPOLIS 46202	GS	134
LINDGREN,IVAN,THURE, 223 MECHANIC ST AURORA 47001	GP	050	LLOYD,JOE,REID, 107 JOHN ST NOBLESVILLE 46060		106
LINDSAY,HAMLIN,BERRY, 511 E MAIN WASHINGTON 47501	GS	046	LLOYD,ROBT,PAUL, 723 FULTON ST FORT WAYNE 46802	GS	082
LINDSETH,RICHARD,E, 1 U MEDICAL CTR INDIANAPOLIS 46202	ORS	134	LO SASSO,ALVIN,M, 1 U MED CENTER INDIANAPOLIS 46202	AN	134
LING,JOHN,FRANCIS, 1250 CHESTER BLVD RICHMOND 47374	GP	314	LOCKE,ROBT,ALLEN, 5943 HOOVER RD INDIANAPOLIS 46208	AN	134
LINGE,CARL,HARBOURT, 401 S E 6TH ST EVANSVILLE 47713	DR	296	LOCKHART,JACK,MACK, 707 W 3RD ST CONNERSVILLE 47331	FP	074
LINGEMAN,RALEIGH,E, 1100 W MICHIGAN RM 56-A INDIANAPOLIS 46202	OTO	134	LOCKHART,PHILIP,BRUCE, 919 E JEFFERSON BLVD RM 107 SOUTH BEND 46622	R	258
LINK,CHAS,WM, 365 E MAIN ST GREENWOOD 46142	GP	158	LODDE,MARVIN,BERNARD, 4200 MILLERWOOD DR KOKOMO 46901	AN	126
LINK,GOETHE, BROOKLYN 46111	GS	134	LOGAN,JAMES,ZIMMERMAN, 1030 N J RICHMOND 47374	ABS	314
LINK,WM,C, 314 W 1ST ST BLOOMINGTON 47401	GP	214	LOGAN,PATRICK,CLIFFORD, 5506 E 16TH ST STE 3 INDIANAPOLIS 46218	D	134
LIONBERGER,JOHN,R, 919 E JEFFERSON BLVD SOUTH BEND 46622	R	258	LOGAN,RICHARD,S, 3124 E STATE ST FORT WAYNE 46805	D	082
LIPSON,JOHN,DAVID, 2530 SANDCREST BLVD COLUMBUS 47201	GS	014	LOH,HWEI-YA,CHANG, 252 MORNINGSIDE AVE GARY 46408	PTH	174

LOH, JEROME, WEI-PING, 600 GRANT ST GARY 46402	PTH	174	LORD, THOS, JOS, 8402 HARCOURT RD 113 INDIANAPOLIS 46260	CD	134
LOHMAN, ROBT, M, 4017 S WAYNE AVE FORT WAYNE 46807	GP	082	LOUCK, MICHAEL, 828 W WASHINGTON AVE RENSSELAER 47978	GP	142
LOHMULLER, HERBERT, W, 303 S MAIN ST BLUFFTON 46714	IM	318	LOUDEN, ROBT, W, 1221 E 86TH ST INDIANAPOLIS 46240	GP	134
LOHOFF, LEWIS, C, PROFESSIONAL BLD TELL CITY 47586	GP	222	LOURIE, BERNARD, 421 CHESTNUT ST EVANSVILLE 47713	IM	296
LONA, MARCO, ANTONIO, 3619 MAIN ST EAST CHICAGO 46312	IM	174	LOVALL, LARRY, D, 8402 HARCOURT ROAD INDIANAPOLIS 46260	FP	134
LONG, MALCOLM, DARRELL, R R 1 BOX 342 WESTFIELD 46074	R	118	LOVE, GEO, NEWTON, 5331 WASHINGTON BLVD INDIANAPOLIS 46220	AN	134
LONG, MAX, RICHARD, 803 S BOOTS ST MARION 46952	GP	098	LOVE, JOHN, WM, 1441 MAPLEWOOD MADISON 47250	P	150
LONG, PAUL, LAPPLE, 828 DRESSER DR ANDERSON 46011	GP	186	LOVE, VINCENT, LOGAN, 1301 S HARRISON ST FORT WAYNE 46802	OM	082
LONGSHORE, ROBT, EUGENE, 1306 WESTBROOK DR KOKOMO 46901	AN	126	LOVELL, MARTIN, HUTSON, 120 W 25TH AVE GARY 46407	GP	174
LONGSTAFF, JOHN, PASCHAL, 715 FIRST AVE EVANSVILLE 47710	P	296	LOVETT, HARVEY, D, 100 N 9TH ZIONSVILLE 46077	GP	022
LOOMIS, CHAS, HENRY, 1030 N J ST RICHMOND 47374	GS	314	LOVING, JURY, BAKER, NEW GOSHEN 47863	GP	298
LOOP, FREDERICK, ADDISON, 296 PARK LANE WEST LAFAYETTE 47906	GS	286	LOWE, JOHN, CHARLES, 1303 N ARLINGTON AVE INDIANAPOLIS 46219	IM	134
LOPEZ, ALFONSO, ESCOBAR, 717 WEST HIGH ST BOX 1085 PORTLAND 47371	GP	146	LOZOW, DAVID, 5626 E 16TH INDIANAPOLIS 46218	ORS	134
LOPEZ, EFREN, RAUL, 502 AMERICAN BANK BLDG VINCENNES 47591	AN	162	LUCAS, CLARENCE, A, 2012 BOULEVARD PL INDIANAPOLIS 46202	GP	134
LOPEZ, FILEMON, PASION, 2167 GETTLER ST DYER 46311	FP	174	LUCAS, JOHN, THOMAS, 3024 FAIRFIELD AVE FORT WAYNE 46807	CLP	082
LOPEZ, SANTIAGO, A, 8127 MERRILLVILLE ROAD MERRILLVILLE 46410	OBG	174	LUCAS, OWEN, HERBERT, 700 SOUTH CALUMET CHESTERTON 46304	FP	230
LORBER, JAMES, MICHAEL, BOX 852 SHELBYVILLE 46176	GS	266	LUCE, JOHN, WEBB, 1225 E COOLSPRING AVE MICHIGAN CITY 46360	OBG	178
LORD, GLENN, CLOVIS, 7437 HOLIDAY DR W INDIANAPOLIS 46260	GP	134	LUCKEY, JAMES, EDWARD, 3 RIVERS NORTH STE 105 FORT WAYNE 46802	AN	082

LUDWIG, PAUL, EDWARD, 408 W MARKET ST CRAWFORDSVILLE 47933	OPH	198	LYON, WM, COCHRAN, 5005 STRATFORD ROAD FORT WAYNE 46807	P	082
LUGINBILL, HOWARD, M, 1303 N ARLINGTON AVE-STE 6 INDIANAPOLIS 46219	P	134	LYSTER, RICHARD, F, 2730 E STATE ST FORT WAYNE 46805	ORS	082
LUK, PETER, 540 TYLER GARY 46402	PTH	174	LYTWAKIWSKY, ANATOL, 807-126TH COURT CROWN POINT 46307	PM	174
LUKEMEYER, GEO, T, 1100 W MICHIGAN ST INDIANAPOLIS 46202	IM	134	M MABEL, THOS, ARTHUR, 901 LAUREL LANE NOBLESVILLE 46060	FP	106
LUKEMEYER, ST, JOHN, 109 W 12TH ST JASPER 47546	GP	066	MAC DONELL, ELDRED, HUGH, 211 N EDDY SOUTH BEND 46617	IM	258
LUNDEBERG, RALPH, ALVIN, 1212 N BROAD ST GRIFFITH 46319	GP	174	MAC DOUGALL, JOHN, D, 1500 ALBANY ST SUITE 702 BEECH GROVE 46107	TS	134
LUNDT, MILO, OLIVER, 330 W LEXINGTON ELKHART 46514	U	070	MAC LENNAN, JOHN, CALVIN, 2600 GREENBUSH ST LAFAYETTE 47904	CD	286
LURDS, JOHN, THEODORE, 1815 N CAPITOL AVE STE 510 INDIANAPOLIS 46202		134	MAC LEOD, DONALD, F, CULVER ED FOUNDATION MED DIR CULVER 46511	PUD	190
LUTHER, WM, C, 3006 EAST LAKE DR S ELKHART 46514	EM	070	MACATANGAY, EDELINO, L, R R 11 BOX 391-B BLOOMINGTON 47401	GP	214
LUTZ, ANDREAS, 8136 KENNEDY AVE HIGHLAND 46322	OBG	174	MACHLEDT, JOHN, HENDRIX, 243 S MADISON ST GREENWOOD 46142	GP	158
LUTZ, GEORGIANNA, 504 BROADWAY GARY 46402	GP	174	MACIAS, RAFAEL, 2208 AMER NAT'L BANK BLDG SOUTH BEND 46601	CDS	258
LUXENBERG, EDWIN, RALPH, 8 CHASE PARK LOGANSPOUT 46947	PD	030	MACKEL, FREDERICK, O, 2609 FAIRFIELD AVE FORT WAYNE 46807	ORS	082
LUZADDER, JOHN, E, 2113 LAKE SHORE DR L B MICHIGAN CITY 46360	FP	258	MACKEL, JERRY, L, 2609 FAIRFIELD AVE FORT WAYNE 46807	ORS	082
LUZIETTI, RICHARD, GILBERT, 303 SOUTH MAIN ST BLUFFTON 46714	IM	318	MACKENZIE, VERONICA, 4617 EAST 46TH ST INDIANAPOLIS 46226	R	134
LY, LILY, ANN U H, 504 W ARCH ST PORTLAND 47371	GF	146	MACKEY, JOHN, EDWARD, 940 W 58TH ST INDIANAPOLIS 46208	OBG	134
LYBROOK, WM, B, 3004 E 52ND ST INDIANAPOLIS 46205	EM	134	MACRI, PAUL, ANGELO CARL, 427 LINCOLN WAY EAST MISHAWAKA 46544	FP	258
LYNCH, HAROLD, DUFF, P O BOX 27 MOUNT VERNON 47620	HEM	296	MACY, GEO, WEBSTER, 5440-25TH ST COLUMBUS 47201	GS	014
LYNN, GENE, EDISON, 1815 N CAPITOL AVE INDIANAPOLIS 46202	P	134			

MADARANG, NAPOLEON, M, 2450 169TH ST HAMMOND 46323	GP	174	MALONE, LEANDER, ALONZO, 2511 NORTH NINTH ST TERRE HAUTE 47804	R	298
MADDEN, ROBT, JOHN, 383 LEISURE LANE GREENWOOD 46142	AN	134	MALOTT, FREDRICK, R, CONVERSE 46919	GP	098
MADER, JOHN, H, 1200 CHESTER BLVD RICHMOND 47374	IM	314	MALOUF, STEPHEN, DAVID, P O BOX 3111 BLOOMINGTON IL 61701	GS	194
MADER, JON, TERRY, NAVAL HOSP DEPT MED PORTSMOUTH VA 23708	IM	314	MAMARIL, BLAS, FLORES, 1107 E BROADWAY LOGANSPOUT 46947	GP	030
MADLANG, RODOLFO, M, 513 RIDGE RD MUNSTER 46321	U	174	MAMMEN, HAROLD, W, 340 S WHITE RIVER PKWY INDIANAPOLIS 46206	OM	134
MADRILEJO, NORA, GUEVARA, 4102 SLEIGHBELL LANE VALPARAISO 46383	AN	174	MANALO, FRANCISCO, SARENAS, 801 JEFFRAS AVE MARION 46952	AN	098
MADRILEJO, ROBERTO, B, 4102 SLEIGHBELL LANE VALPARAISO 46383	OM	174	MANDEL, DARREL, SHELDON, 8315 CLARIDGE RD INDIANAPOLIS 46260	R	134
MADTSON, ALFRED, R, 1815 N CAPITOL ROOM 307 INDIANAPOLIS 46202	GS	134	MANDELBAUM, ISIDORE, INDIANA UNIV MED CTR INDIANAPOLIS 46202	TS	134
MADURA, JAMES, ANTHONY, 1100 W MICHIGAN INDIANAPOLIS 46202	GS	134	MANDERS, KARL, L, 5506 E 16TH ST INDIANAPOLIS 46218	NS	134
MAGBAG, WENCESLAO, G, LIN ST CORNER OF 5TH AVE HOLLAND 47541	GP	066	MANGAHAS, JUVENCIO, P, 7441 ARKANSAS HAMMOND 46323	FP	174
MAGLINTE, DEAN, D T, 1433 BREWSTER RD INDIANAPOLIS 46260	OS	134	MANGAHAS, VIOLETA, RIVERA, 7441 ARKANSAS AVE HAMMOND 46323	AN	174
MAGNO, JOSE, NOCUM, V A HOSPITAL MARION 46952	P	098	MANHART, DOYLE, BASLER, 501 E 5TH ST SHERIDAN 46069	GP	106
MAGNUSON, CHAS, W, 211 EDDY AT COLFAX SOUTH BEND 46617	GE	258	MANIFOLD, HAROLD, MORRIS, 1920 E 3RD ST BLOOMINGTON 47401	GP	214
MAHANK, CAMIEL, CYRIEL, 303 S MAIN ST MISHAWAKA 46544	OBG	258	MANION, MARLOW, WM, 5132 N NEW JERSEY ST INDIANAPOLIS 46205	OTO	134
MAKOVSKY, THEODORE, 1005 CAMPBELL ST VALPARAISO 46383	GP	230	MANKIN, WM, J, 1655 N 7TH ST TERRE HAUTE 47801	OPH	298
MALACHOWSKI, ROBT, MICHAEL, 6314 N RUCKER INDIANAPOLIS 46220	PD	134	MANLEY, FLOYD, 6010 COLUMBIA AVE HAMMOND 46320	GP	174
MALDIA, GODOFREDO, MAYUGA, 3030 LAKE AVE FORT WAYNE 46805	ON	082	MANN, MORTIMER, 3266 N MERIDIAN APT 401 INDIANAPOLIS 46208	OPH	134
MALIK, MUHAMMAD, IQBAL, 3232 NORTH MERIDIAN ST WINONA HOSP PATH DEPT INDIANAPOLIS 46208	PTH	134	MANN, RICHARD, EUGENE, 3010 E STATE BLVD FORT WAYNE 46805	P	082

MANNING,GEO,C, 534 W BERRY ST FORT WAYNE 46802	NS	082	MARKS,SALVO,PHILIP, 6860 HOHMAN HAMMOND 46324	OPH	174
MANNING,GEO,WESTON, RT NO 1 PRAIRIE MEADOWS COLUMBIA MO 65201	P	296	MARKSTONE,DAVID,HAROLD, 1100 WEST MICHIGAN INDIANAPOLIS 46202	OPH	134
MANNING,K,RANDOLPH, 1815 NORTH CAPITOL AVE INDIANAPOLIS 46202	ORS	134	MARQUINEZ,ADORACION,A, 5217 HOHMAN AVE HAMMOND 46320	AN	174
MANNION,RODNEY,ANTHONY, FOX VILLAGE MED BLDG LA PORTE 46350	U	178	MARQUIS,GORDON, 211 N EUDY AT COLFAX SOUTH BEND 46617	OTO	258
MANSHIP,CECIL,STANLEY, BOX 118 HARDINSBURG 47125	GP	310	MARR,GRIFFITH, R R 1 BOX 10 MARR ROAD COLUMBUS 47201	AN	014
MANSUETO,MARIO,DANL, 509 RIDGE RD MUNSTER 46321	HNS	174	MARKESE,ROCCO,A, 801 ST MARYS DR SUITE 202 EVANSVILLE 47715	ORS	296
MANUEL,LETICIA,M, 124 EAST SIXTH STREET CONNERSVILLE 47331	PD	074	MARSH,CARL,M, 131 N SHORTRIDGE RD INDIANAPOLIS 46219	GP	134
MANZANARES,AUSTACIO,F, 2920 OHIO BLVD TERRE HAUTE 47803	AN	298	MARSH,GEO,WILBUR, 1216 HOWELL ST LAFAYETTE 47904	GP	286
MANZANO,EDMUNDO,V, 9513 DOGWOOD LN MUNSTER 46321	AN	174	MARSHALL,THOMAS,W, 3200 SYCAMORE COURT COLUMBUS 47201	ORS	014
MANZIE,MICHAEL,WM, 9040 ASHWORTH CT INDIANAPOLIS 46260	ABS	134	MARSHALL,WILBUR,JAMES, 7905 CALUMET AVE MUNSTER 46321	OBG	174
MARCHAND,EDWIN,VICTOR, 5700 WARD ROAD EVANSVILLE 47711	GP	094	MARSKE,ROBT,L, 1713 BUFFALO MICHIGAN CITY 46360	PD	178
MARCUS,MURRIS,C, 3229 BKROADWAY GARY 46409	OTO	174	MARTIN,ALLEN,S, BOX 187 SHIPSHAWANA 46565	GP	170
MARHENKE,JON,DAVID, 1815 NORTH CAPITOL AVE NO 202 INDIANAPOLIS 46202	P	134	MARTIN,CHAS,F, 5610 SOUTH YORK RD SOUTH BEND 46614	R	258
MARIANO,ARTURO,S, 46 STONEGATE DR INDIANAPOLIS 46227	OBG	158	MARTIN,DAVID,LEE, R R 4 BOX 152 PENDLETON 46064	D	186
MARIENAU,DAVID,J, SUITE 112 MEDICAL ARTS EVANSVILLE 47715	FP	296	MARTIN,DONALD,LANE, 304 E MARKET ST SALEM 47167	GP	310
MARKS,HOWARD,HARLEY, 248 W PARK DR HUNTINGTON 46750	GP	130	MARTIN,JOHN,PHILLIP, 105 THREE RIVERS NGRTH FORT WAYNE 46802	AN	082
MARKS,JOHN,SCOTT, 5506 E 16TH ST INDIANAPOLIS 46218	NS	134	MARTIN,LOREN,HAROLD, 2626 W WASHINGTON ST INDIANAPOLIS 46222	FP	134
MARKS,ORA,LEONARD, 815 W CHICAGO AVE EAST CHICAGO 46312	OBG	174	MARTIN,NOEL,JACKSON, 1509 WASHINGTON ST BOONVILLE 47601	EM	306

MARTIN,SAML,W, R R 5 BOX 342 CURYDON 47112	GP	114	MASON,RICHARD,L, 130 RIDGE ROAD MUNSTER 46321	R	174
MARTINEZ,GUILLERMO,G, 502 3RD ST AURORA 47001	GS	050	MASSANARI,WALTER,S, 211 EGBERT RD GOSHEN 46526	AN	070
MARTINO,ROBERT,S, 5587 BROADWAY MERRILLVILLE 46410	OKS	174	MASSER,FRANCES,JOAN, 210 SPARKS AV JEFFERSONVILLE 47130	PTH	034
MARTINOV,W,M,EDWARD, 919 E JEFFERSON SOUTH BEND 46622	CDS	258	MASSUDA,YACCOUB, 8122 OAKWOOD AVE MUNSTER 46321	AN	174
MARTIREZ,NAPOLEON,A, 4710 INDIANAPOLIS BLVD EAST CHICAGO 46312	GS	174	MASTERS,JOHN,MELVIN, 34 EAST 46TH ST INDIANAPOLIS 46205	OPH	134
MARTZ,BILL,L, 216 W TILDEN RD BROWNSBURG 46112	PA	134	MATHER,CHAS,R, 2600 GREENBUSH LAFAYETTE 47902	OBG	286
MARTZ,CARL,D, 8402 HARCOURT RD APT 209 INDIANAPOLIS 46260	ORS	134	MATHER,GLENN,BURTON, BLOOMINGTON HOSP BLOOMINGTON 47401	NM	214
MARVEL,HOWARD,ROLAND, 2600 GREENBUSH ST LAFAYETTE 47902	A	286	MATHER,J,WINFORD, 2250 RIPLEY ST EAST GARY 46405	GP	174
MARVEL,JAMES,ANDREW, 421 CHESTNUT ST EVANSVILLE 47713	A	296	MATHER,ROBT,LINCOLN, 805 PURDUE NATIONAL BANK BLDG LAFAYETTE 47901	UPH	286
MARVEL,ROBT,J, 600 ARLINGTON ST GREENCASTLE 46135	IM	242	MATHEU,HERACLEO,I, 733 S BUFFALO WARSAW 46580	P	166
MASBAUM,NEO,PAUL, 1010 EAST 86TH STE 48 INDIANAPOLIS 46240	P	134	MATHEW,PALLIPEEDIKAIL,C, 1775 NORTH JEFFERSON ST HUNTINGTON 46750	GP	130
MASCHMEYER,ROBT,HENRY, R R 1 BOX 122A ZIONSVILLE 46077	D	134	MATHEWS,FRANKLIN, 1502 HARTFORD ST SUITE 102 LAFAYETTE 47904	N	286
MASON,BERNARD,A, 211 NORTH EDDY ST SOUTH BEND 46617	IM	258	MATHEWS,JAMES,R, 901 S MEADOW RD EVANSVILLE 47715	R	296
MASON,DONALD,GOODING, 112 S WAYNE ST ANGOLA 46703	GP	278	MATHEWSON,RUSSELL,C, R R 9 BOX 157 MUNCIE 47302	P	062
MASON,EARL,JAMES, 540 TYLER STREET GARY 46402	PTH	174	MATLOCK,CARL,KENT, 746 NORTH ST GREENFIELD 46140	GP	110
MASON,EVERETT,ELMORE, 3700 BELLEMEADE EVANSVILLE 47715	GP	296	MATTHEW,JOHN,ROBT, 317 CARLSON DR KNOX 46534	GPM	274
MASON,JOHN,CHAS, 7905 CALUMET AVE MUNSTER 46321	GP	174			
MASON,LESTER,MILLARD, MERCHANTS BK BLDG 314 TERRE HAUTE 47801	D	298	MATTHEWS,LELAND,RAY, 421 W 1ST ST BLOOMINGTON 47401	OBG	214

MATTHEWS,WM,M, 1100 W MICHIGAN ST INDIANAPOLIS 46202	AN	134	MC ALLISTER,ALLAN,J, 1000 NORTH 16TH STREET NEW CASTLE 47362		122
MATTOX,DEAN,LLLOYD, FAMILY PHYSICIANS INC BOX 210 LAGRANGE 46761	GP	278	MC ALPINE,RICHARD,J, WABASH CLINIC 400 ASH ST WABASH 46992	GP	302
MATZEN,RICHARD,NORMAN, 301 SOUTH MAIN ST BLUFFTON 46714	PUD	318	MC ARDLE,MICHAEL,L, 2609 FAIRFIELD AVE FORT WAYNE 46807	ORS	082
MAURER,ROBT,MARION, 111 N WALNUT ST BRAZIL 47834	GP	038	MC AREE,FRANCIS,EDWARD, 5521 OVERBROOK CR INDIANAPOLIS 46226	OBG	134
MAUS,RONALD,TRENT, 800 S BERKLEY KOKOMO 46901	FP	126	MC ART,BRUCE,A, 1332 W INDIANA ELKHART 46514	GS	070
MAUZY,MERRITT,C, 216 SHERLAND BLDG SOUTH BEND 46601	PS	258	MC ATEE,OTT,BENTON, MADISON STATE HOSP MADISON 47250		150
MAXAM,BEVERLY,TRENT, 3524 N MERIDIAN ST INDIANAPOLIS 46208	GE	134	MC BRIDE,J,WILLIAM, PORTER MEM HOSP VALPARAISO 46383	PTH	230
MAXSON,ROY,VERNON, WINDRIDGE OFFICE BLDG STE 115 5435 EMERSON WAY NORTH INDIANAPOLIS 46226	AN	134	MC BRIDE,NOEL,SAMUEL, MERCHANTS BANK BLDG 407 TERRE HAUTE 47801	GPH	298
MAY,RICHARD,MILTON, LACONIA 47135	GP	114	MC BRIDE,ROBT,EDMUND, P O BOX 341 MICHIGAN CITY 46360	PTH	178
MAYHUE,HUGH,WAYNE, 207 SPARKS AVE JEFFERSONVILLE 47130	OBG	034	MC CALLA,CHAS,X, BOX 151 PAOLI 47454	FP	210
MAYOCK,PETER,PAUL, 303 S MAIN ST BLUFFTON 46714	D	318	MC CALLISTER,JOHN,WM, 3124 E STATE ST FORT WAYNE 46805	GS	082
MAYROSE,RICHARD,SMITH, 1645 NORTH 7TH ST TERRE HAUTE 47802	GP	298	MC CALLUM,DONALD,CAKEY, 1815 N CAPITOL AVE 403 INDIANAPOLIS 46202	U	134
MAZDAI,ABOUZARJOMEHR, 707 W 3RD ST CONNERSVILLE 47331	GS	074	MC CALLUM,JAMES,JOS, 8402 N HARCOURT RD STE 610 INDIANAPOLIS 46260	OPH	134
MC ADAMS,HUGH,BEST, MEDICAL ARTS BLDG 2500 FERRY ST LAFAYETTE 47904	GP	286	MC CARDLE,ROBT,ALAN, 777 N WOLFENBERGER ST SULLIVAN 47882	IM	282
MC ADAMS,ROBT,C, 2011 KOSSUTH ST LAFAYETTE 47905	GP	286	MC CARTHY,JOSEPH,CLARK, R R 3 BOX 748 NEWBURGH 47630	EM	296
MC ALEAVEY,PATRICK,JOS, 4167 NORTH WASHINGTON AVE INDIANAPOLIS 46205	AN	082	MC CARTHY,LEO,JOS, 532 WELLINGTON ROAD INDIANAPOLIS 46260	PTH	134
MC ALEESE,GEO,BUCHANAN, 1024 SOUTH 6TH ST TERRE HAUTE 47807	GS	298	MC CARTNEY,DONALD,H, 1500 ALBANY ST SUITE 705 BEECH GROVE 46107	ORS	134
			MC CARTY,VIRGIL, P O BOX 45 PRINCETON 47670		094

MC CASLIN,DAN,LESTER, 1301 S HARRISON ST FORT WAYNE 46602	R	082	MC CURDY,ROBERT,WILLIAM, 2117 E 5 STREET ANDERSON 46012	GS	186
MC CLAIN,EDWIN,S, 8402 HARCOURT RD INDIANAPOLIS 46260	OBG	134	MC DANIEL,EDWIN,CORR, 1815 N CAPITOL AVE SUITE 403 INDIANAPOLIS 46202	U	134
MC CLAIN,MARVIN,LEVI, 384 E MC CLAIN ST SCOTTSBURG 47170	GP	262	MC DONALD,FRANK,C, 365 TROJAN LANE NEW CASTLE 47362	GP	122
MC CLARY,CHAS,WENDELL, 839 AUTO MALL RD BLOOMINGTON 47401	FP	214	MC DONALD,JOS,DOUGLAS, 4300 LINCOLN AVE EVANSVILLE 47715	GS	296
MC CLINTOCK,JAMES,A, 316 W ADAMS ST MUNCIE 47305	GS	062	MC DONALD,WALTER,EVERETT, 2200 GRANT ST GARY 46404	GS	174
MC CLOUD,L,C, CLARK COUNTY HOSP JEFFERSONVILLE 47130	PTH	034	MC DOUGAL,BUD,HOLLAND, 8402 HARCOURT ROAD NO 417 INDIANAPOLIS 46260	GS	134
MC CLURE,GLEN, 777 N WOLFENBERGER SULLIVAN 47882	GS	282	MC DOUGAL,ROBT,A, HENDRICKS COUNTY HOSPITAL DANVILLE 46122	PTH	116
MC CLURE,STANLEY,EDWIN, 205 HILLCREST ROAD OAK PARK MONTICELLO 47960	GP	322	MC DOWELL,FLETCHER,W, 926 W MAIN ST MUNCIE 47305	GS	062
MC CLURE,WARREN,N, 319 S BERKLEY RD KOKOMO 46901	FP	126	MC DOWELL,GEO,ARNOLD, 215 MEDICAL CTR BLDG FORT WAYNE 46802	GP	082
MC CONNELL,THOS,LEE, 705 S CATALPA DR MUNCIE 47304	FP	062	MC DOWELL,MORDECAI,M, 1322 AUDUBON RD VINCENNES 47591	IM	162
MC CONNELL,WM,CHAS, 512 N MERIDEAN ST SUNMAN 47041	GP	250	MC DOWELL,RICHARD,LEE, P O BOX 268 FORT WAYNE 46801	PTH	082
MC COOL,JOE,HENRY, 1 WOODMERE DR EVANSVILLE 47711	P	296	MC EACHERN,CECIL,G, 2424 FAIRFIELD AVE FORT WAYNE 46807	GS	082
MC CORD,GEO,ELLIOTT, 5506 E 16TH ST INDIANAPOLIS 46218	UPH	134	MC ELROY,JAMES,STEWART, 1213 AUDUBON ROAD NEW CASTLE 47362	GS	122
MC COY,MELVIN,HOWARD, LOT 20 COLONIAL HILLS NEWBURGH 47630	P	296	MC ELROY,JAMES,THOS, 8402 HARCOURT RD INDIANAPOLIS 46260	IM	134
MC COY,ROY,RALSTON, 3701 S HARRISON ST FORT WAYNE 46807		082	MC ELROY,ROBT,JON, 515 READ ST EVANSVILLE 47710	IM	296
MC CREA,FRED,RONALD, 221 S 6TH ST TERRE HAUTE 47801	R	298	MC ELROY,ROBT,SAML, 116 S MAIN ST PRINCETON 47670	ABS	094
MC CULLOUGH,HENRY,G, R D 4 COLUMBUS 47201	GP	014	MC EWEN,DAVID,AIKIN, 2600 GREENBUSH ST LAFAYETTE 47904	DR	286
MC CULLOUGH,JAMES,Y, 700 E SPRING ST NEW ALBANY 47150	GS	078	MC FADDEN,JAMES,M, 2500 FERRY ST LAFAYETTE 47904	PTH	286

MC FADDEN,WILBUR,DEAN, 1104 N WAYNE NORTH MANCHESTER 46962	GP	302	MC NEELY,MATTHEW,J, 36 BAY VIEW PARADISE BAY PK BRADENTON FL 33507	GP	050
MC FARLAND,CORLEY,B, 211 NORTH EDDY AT COLFAX SOUTH BEND 46617	OPH	258	MC NUTT,CYRUS,CHARLES, 8639 LANCASTER RD INDIANAPOLIS 46260	AN	134
MC GARVEY,WILLIAM,K, 8402 HARCOURT RD INDIANAPOLIS 46260	OTO	134	MC PHEKSON,RICHARD,CLARK, 2600 GREENBUSH ST LAFAYETTE 47902	GS	286
MC GILL,JOEL,LEWIS, 213 EAST CROSS ST BROWNSTOWN 47220	PD	138	MC QUADE,JOHN,ALLEN, 1522 PORTAGE SOUTH BEND 46616	GP	258
MC GRAW,WM,ELMER, 1815 N CAPITAL INDIANAPOLIS 46202	DR	134	MC QUISTON,RALPH,J, 6120 LAWRENCE DR INDIANAPOLIS 46226	OTO	134
MC INERNEY,GEKALD,T, 3136 CLEVELAND AVE MICHIGAN CITY 46360	CD	178	MC QUISTON,ROBT,DOUGLAS, 20 NORTH MERIDIAN ST INDIANAPOLIS 46204	OTO	134
MC INTIRE,CLARENCE,R, BOX 1149 BLOOMINGTON 47401	K	214	MC WILLIAMS,WM,BRYAN, R R 2 LIBERTY 47353	GP	314
MC INTOSH,WILBERT, RILEY 47871	GP	298	MEADE,DONNA,JOAN, 5699 E 71ST ST INDIANAPOLIS 46220	IM	134
MC INTYRE,JAMES,MURRAY, 1815 N CAPITAL INDIANAPOLIS 46202	CRS	134	MEALEY,JOHN, 1100 W MICHIGAN ST INDIANAPOLIS 46202	NS	134
MC KEE,HARRY,G, 208 W 1ST ST RUSHVILLE 46173	GP	254	MEDINA,ANGELINA,VELOIRA, 800 MACARTHUR BLVD SUITE 5 MUNSTER 46321	GP	174
MC KEE,ROY,G, 606 N FAIR OAKS NEW CASTLE 47362	GP	122	MEDINA,HERBERT,LEONARDO, 800 MAC ARTHUR BLVD S-5 MUNSTER 46321	GP	174
MC KINLEY,A,DAVID, I U MEDICAL CENTER INDIANAPOLIS 46202	CD	134	MEGENHARDT,DENNIS,S, 3266 N MERIDIAN STE 606 INDIANAPOLIS 46208	GS	134
MC KINLEY,JOS, 2600 GREENBUSH ST LAFAYETTE 47904	U	286	MEGREMIS,THEODURE,L, BOX 1149 BLOOMINGTON 47401	R	214
MC KINNEY,DONALD,LEROY, BOX 398 OTTERBEIN 47970	FP	286	MEIER,DONALD,W, 303 S MAIN ST BLUFFTON 46714	GS	318
MC LAREN,DANL,EDWARD, 6000 E 46TH ST INDIANAPOLIS 46226	FP	134	MEISER,ROBT,DEWITT, P O BOX 733 HUNTINGTON 46750	UPH	130
MC LAUGHLIN,JAMES,R, 511 E MAIN ST FLORA 46929	GP	026	MEISSEL,ROBT,LEE, 1655 N 7TH ST TERRE HAUTE 47804	FP	298
MC MAHAN,VIRGIL,CARROL, 609 DU BOIS ST VINCENNES 47591	ORS	162	MELCHIOR,JEROME,EDWARD, 615 DUBOIS ST VINCENNES 47591	U	162
MC MEEL,JAMES,EUGENE, 2604 S THYCKENHAM SOUTH BEND 46614	OM	258	MELIN,JOHN,R, 3266 N MERIDIAN ST NO 603 INDIANAPOLIS 46208	OBG	134

MELLINGER, MICHAEL, OWEN, 300 NORTH TOWNLINE ROAD LAGRANGE 46761	GP	170	MESSER, FRANK, WILBURN, 115 E RUSH ST KENDALLVILLE 46755	GP	206
MELTON, MARVIN, EUGENE, 2001 WEST 86TH INDIANAPOLIS 46260	PTH	134	METCALFE, GRANT, EMORY, 919 E JEFFERSON BLVD SOUTH BEND 46622	P	258
MENCIA, LEON, A, 5906 FIELDCREST LANE INDIANAPOLIS 46241	GS	134	MEYER, CLAUDE, JAMES, 207 SPARKS AVE STE 200 JEFFERSONVILLE 47130	GP	034
MENDELSON, STANLEY, M, 401 E REYNOLDS DR KOKOMO 46901	GP	126	MEYER, HERMAN, ARTHUR, 1030 W WAYNE ST FORT WAYNE 46804	GP	082
MENDOZA, FELICISIMO, SUNGA, 710 PARKWAY DR CAMBRIDGE CITY 47327	GP	074	MEYER, THEODORE, OBED, 3728 KIRKWOOD DR FORT WAYNE 46805	OPH	082
MENGELT, THOS, PAUL, 1800 NORTH 8 STREET ELWOOD 46036	GP	186	MEYERS, MARK, ELMER, 1108 GLEN MOORE CT EVANSVILLE 47715	FP	296
MENSCH, JAMES, R, 2120 FOREST PARK BLVD FORT WAYNE 46805	AN	082	MEYERS, WM, LOUIS, RT 3 SYRACUSE 46567	GP	070
MENTENDIEK, MARY, ANN, 5699 E 71ST INDIANAPOLIS 46220	IM	134	MICHAEL, ISAAC, ELDREW, 2020 WEST 86TH ST INDIANAPOLIS 46260	IM	134
MENTZER, WM, GILBERT, 2400 FERRY ST LAFAYETTE 47904	OEG	286	MICHAEL, ROBT, L, 3423 C S LAFOUNTAINE KOKOMO 46901	GS	126
MERCER, SAML, R, 710 MEDICAL CTR BLDG FORT WAYNE 46802	D	082	MICHL, LEON, GEO, R R 1 CANAAN 47224	GS	150
MERCHO, JEAN, PHARAON, 1213 N ARLINGTON INDIANAPOLIS 46219	GS	134	MIDDLETON, HARVEY, N, 1828 N ILLINOIS ST INDIANAPOLIS 46202	IM	134
MEREDITH, JESSE, H, 202 SOUTH WEST ST TIPTON 46072	FP	290	MIDDLETON, RAMONA, J, 1400 HUDSON ST ELKHART 46514	OBG	070
MERICLE, EARL, WM, 8455 WASHINGTON BLVD INDIANAPOLIS 46240	P	134	MIDDLETON, THOS, O, PO BOX 457 BLOOMINGTON 47401	PD	214
MERKLE, GEO, WALLACE, 303 S MAIN ST BLUFFTON 46714	FP	318	MIETHKE, RICHARD, PAUL, DELCO RADIO DIV KOKOMO 46901	OM	126
MERNITZ, ROLAND, BALDWIN, 400 ASH ST WABASH 46992	GS	302	MIKLOZEK, JOHN, EDMUND, 660 IDAHO TERRE HAUTE 47802	GP	298
MERRITT, ARTHUR, D, 1100 W MICHIGAN ST INDIANAPOLIS 46202	GER	134	MIKULASCHEK, WALTER, M, 4149 EAGLES ROOST DR INDIANAPOLIS 46234	RHU	134
MERTZ, JOHN, HENRY O, 1711 N CAPITOL AVE INDIANAPOLIS 46202	U	134	MILAN, JOS, F, 619 WEST 1ST ST BLOOMINGTON 47401	GS	214
MESHBERGER, FRANK, LYNN, 3266 N MERIDIAN #302 INDIANAPOLIS 46208	OBG	134	MILAN, SHIJACHKI, DUSHAN, 622 W CHICAGO AVE EAST CHICAGO 46312	GP	174

MILLAN, FELIX, 1117 MELBROOK DR MUNSTER 46321	PM	174	MILLER, JOHN, DAVID, 3530 SOUTH KEYSTONE AVE INDIANAPOLIS 46227	PUD	134
MILLAN, JOSELITO, LECAROS, MED ARTS BLDG 207 SPARKS AVE JEFFERSONVILLE 47130	NS	034	MILLER, JOS, A, 11929 EAST 65TH ST OAKLANDON 46236	GP	110
MILLER, ALBERT, JOHN, 2500 FERRY ST LAFAYETTE 47904	PTH	286	MILLER, KENNETH, DEVON, BOX 128 WOODBURN 46797	EM	082
MILLER, DAN, TUCKER, 100 N MADISON FOWLER 47944	GS	018	MILLER, L, HOYT, 6000 E 46TH ST INDIANAPOLIS 46226	FF	134
MILLER, DENNIS, WARREN, P O BOX 163 ZIONSVILLE 46077	AN	134	MILLER, LA, VERNE BAXTER, 1421 N MAIN ST EVANSVILLE 47711	GP	296
MILLER, DON, EUGENE, 2828 FAIRFIELD AVE FORT WAYNE 46807	IM	082	MILLER, MARSHALL, S, 421 CHESTNUT ST EVANSVILLE 47713	IM	296
MILLER, DONALD, C, 13963 MORSE ST CEDAR LAKE 46303	GP	174	MILLER, MAURICE, 1225 E COOLSPRING MICHIGAN CITY 46360	GP	178
MILLER, EDWARD, DWAYNE, 3030 LAKE AVE FORT WAYNE 46805	OPH	082	MILLER, RICHARD, CHAS, 17 W MECHANIC ST SHELBYVILLE 46176	GP	266
MILLER, ELGAN, LEE, 305 PROFESSIONAL ARTS BLDG 1919 STATE STREET NEW ALBANY 47150	OBG	078	MILLER, RICHARD, HENRY, 511 W WAYNE ST FORT WAYNE 46802	GS	082
MILLER, FRANK, HINER, 5506 E 16TH ST INDIANAPOLIS 46218	OPH	134	MILLER, ROBT, BENJ, 3124 E STATE ST FORT WAYNE 46805	UTO	082
MILLER, GARY, LEE, 1201 MICHIGAN AVE LOGANSPOET 46947	GS	030	MILLER, ROBT, JOHN, RT 3 BOX 180 MARTINSVILLE 46151	GP	202
MILLER, HAROLD, L, 1250 CHESTER BLVD RICHMOND 47374	ORS	314	MILLER, ROLAND, EDWARD, 2200 SCOTT ST LAFAYETTE 47904	PD	286
MILLER, HUGH, A, PECK ACADEMY RD RR #2 CONSTANTINE MI 49042	IM	070	MILLER, RUSCOE, E, 1100 W MICHIGAN ST INDIANAPOLIS 46202	DR	134
MILLER, J, THOS, 700 BROADWAY FORT WAYNE 46802	R	082	MILLER, SAM, L, T, 5892 EASY STREET APT L NO 25 BRADENTON FL 33507	GP	070
MILLER, JAMES, CATRON, 317 N FRANKLIN ST GREENSBURG 47240	GP	054	MILLER, STEPHEN, THOS, 5508 E 16TH INDIANAPOLIS 46218	GS	134
MILLER, JAMES, RALPH, P O BOX 446 WAKARUSA 46573	GP	070	MILLER, WM, AMON, 99 S WASHINGTON HAGERSTOWN 47346	GP	122
MILLER, JERRY, ALLEN, 3266 N MERIDIAN ST NO 407 INDIANAPOLIS 46208	AN	134	MILLER, WM, JOS, 58 THISE COURT LAFAYETTE 47905	R	286
MILLER, JERRY, ROLAND, 1100 W MICHIGAN ST INDIANAPOLIS 46202	AN	134	MILLIS, ARTHUR, B, 1250 CHESTER BLVD RICHMOND 47374	PM	314

MILLS, FRED, EDWARD, DEACONESS HOSPITAL EVANSVILLE 47710	PTH	296	MITCHELL, GEORGIA, BONE, 1706 BROADWAY GARY 46407	GP	174
MILNE, WALTER, SCOTT, 916 WASHINGTON ST MICHIGAN CITY 46360	IM	178	MITCHELL, JAMES, PAUL, 615 W FIRST ST BLOOMINGTON 47401	AN	214
MILOS, ROBT, JOS, 8127 MERRILLVILLE RD MERRILLVILLE 46410	GS	174	MITCHELL, JOHN, B, MEAD JOHNSON CO-RESEARCH DIV EVANSVILLE 47721	PD	296
MIN, DAVID, PYONG-WHA, 800 MACARTHUR BLVD MUNSTER 46321	DBG	174	MITMAN, URSULA, E, RR 2 BOX 322 PLAINFIELD 46168	DR	118
MINCZEWSKI, RICHARD, C, 5490 BROADWAY PLAZA MERRILLVILLE 46410	GP	174	MITRE, ISAAC, NAZRI, 1645 NORTH 7TH STREET TERRE HAUTE 47804	DBG	296
MINICK, LINUS, J, WHITLEY AT MULBERRY CHURUBUSCO 46723	GP	082	MLADICK, EDWARD, A, 1110 INDIANA AVE LA PORTE 46350	ORS	178
MINKIN, RONALD, BLAINE, 7905 CALUMET MUNSTER 46321	D	174	MOAK, GLENN, D, 4339 ROYAL PINE BLVD INDIANAPOLIS 46250	R	134
MINTER, DONALD, LEE, 110 W HIGH PARK AVE GOSHEN 46526	GP	070	MOATS, CARL, FRANKLIN, 4007 S WAYNE AVE FORT WAYNE 46807	GP	082
MINTZ, ALFRED, M, 800 MACARTHUR BLVD MUNSTER 46321	OKS	174	MOAYAD, CYRUS, 1105 E GLNDALE BLVD VALPARAISO 46383	OTO	230
MIRANDA, CONRADO, R, 702 BROWNE ST WINCHESTER 47394	GS	246	MOCK, LAWRENCE, FARRELL, 303 S MAIN ST BLUFFTON 46714	ORS	318
MIRICH, ERNEST, C, 500 WEST LINCOLN HIGHWAY MERRILLVILLE 46410	CD	174	MODISETT, JACKSON, W, 722 W MAIN ST MADISON 47250	GP	150
MIRKES, SEYMOUR, HOWARD, 102 DOWNING COURT NOBLESVILLE 46060	DK	106	MODISETT, MARCELLA, L S, 722 W MAIN ST MADISON 47250	DBG	150
MIRRO, JOHN, ANTHONY, 6111 HARRISON MERRILLVILLE 46410	GP	174	MOELLER, VICTOR, C, 2424 FAIRFIELD AVE FORT WAYNE 46807	GP	082
MISCH, WM, A, 13963 MUNSE ST CEDAR LAKE 46303	GP	174	MOENNING, JOHN, EDWARD, 120 W MC KENZIE GREENFIELD 46140	GS	110
MISHKIN, IRVING, 209 S 2ND ST ELKHART 46514	GP	070	MOFFETT, JAMES, B, 40 DEERPATH ROAD MERRILLVILLE 46410	A	174
MISHKIN, MARVIN, ELI, 209 S 2ND ST ELKHART 46514	IM	070	MOHEBAN, JOS, 120 W WASHINGTON SHELBYVILLE 46176	GP	266
MISHLER, JOE, BILL, BOX 134 PIERCETON 46562	FP	326	MOHLER, FLOYD, W, 2060 DOCTORS PARK DR COLUMBUS 47201	ORS	014
MITCHELL, GARY, ALAN, 912 E LA SALLE ST SOUTH BEND 46617	NEP	258	MOHRMAN, MICHAEL, S, 3217 LAKE AVE FORT WAYNE 46805		082

OHRS, PAUL, EDWARD, 405 LIFE BLDG LAFAYETTE 47901	AN	286	MOORE, JOHN, MANSFIELD, 3807 SOUTHLAND AVE KOKOMO 46901	OBG	126
OK, LYNN, CHANG, 8500 WHETSTONE RD EVANSVILLE 47711	AN	296	MOORE, ROBT, GARDNER, RFD 1 BICKNELL 47512	OR	162
OK, YING, BUNG, 421 CHESTNUT ST EVANSVILLE 47713	ORS	296	MOORE, THOMAS, S, 8801 NORTH MERIDIAN ST INDIANAPOLIS 46260	PS	134
OLENGRAFT, CORNELIUS, J., 504 BROADWAY GARY 46402	OBG	174	MOORE, THOS, O, 8801 NORTH MERIDIAN ST NO 206 INDIANAPOLIS 46260	FP	134
ONAR, MICHAEL, O, 6TH AND MAIN ROCKPORT 47635	GP	270	MOORE, WM, GILBERT, OSMIC PLACE LA PORTE 46350	GS	178
ONEYHUN, JAMES, EMMETT, 2009 BROWN ST ANDERSON 46014	GP	186	MOOKES, WM, BRADLEY, 2205 DURHAM INDIANAPOLIS 46220	D	134
ONN, LARRY, NEIL, 5626 EAST 16TH ST INDIANAPOLIS 46218	PS	134	MOOSEY, LOUIS, 609 S WATER ST UNION MILLS 46382	GP	178
ONTECILLO, ANTULIN, M, 257 WALNUT ST CLINTON 47842	GP	218	MOOSEY, NEALE, ANTHONY, 1213 N ARLINGTON INDIANAPOLIS 46219	U	134
ONTES, HERMINIO, Y, 7915 HOHMAN AVE MUNSTER 46321	AN	174	MORAN, THOS, EDWARD, 7150 MADISON AVE INDIANAPOLIS 46227	GP	134
ONTGOMERY, CHARLES, E, 5204 WAPITI DRIVE FORT WAYNE 46804	OKS	082	MOREC, GEO, JAMES, 1007 N 16TH ST NEW CASTLE 47362	PD	122
ONTGOMERY, LALL, G, BALL MEMORIAL HOSPITAL MUNCIE 47303	PTH	062	MORETTO, THOS, JAMES, R R 2 BOX 337 CARMEL 46032	FP	134
ONTGOMERY, RALPH, F, 2501 W JACKSON MUNCIE 47303	OBG	062	MOREY, EDWIN, E, 2828 FAIRFIELD AVE FORT WAYNE 46802	OBG	082
ONTUORI, GIULIA, 404 SHOREWOOD COURT VALPARAISO 46383	GPM	174	MORFORD, GUY, 2207 E MAXWELL LNE BLOOMINGTON 47401	AN	214
OOORE, DONALD, CHARLES, P O BOX 1480 COLUMBUS 47201	R	014	MORGAN, MARGARET, ELAINE, 4144 N PENNSYLVANIA INDIANAPOLIS 46205	P	134
OOORE, DONALD, FLOYD, 1315 W 10TH ST INDIANAPOLIS 46207	P	134	MORGAN, MILTON, MELVIN, 4628 S CALHOUN FORT WAYNE 46807	GS	082
OOORE, EDWIN, GRIFFEN, 26 E 15TH GARY 46407	GP	174	MORGAN, RANDALL, C, 636 EAST 21ST AVE GARY 46404	GRS	174
OOORE, HAROLD, T, 1815 N CAPITOL INDIANAPOLIS 46202	AN	134	MORGAN, ROBT, JOS, 5626 EAST 16TH ST INDIANAPOLIS 46218	ObG	134
OOORE, JACK, CONRAD, 1904 W MC GALLIARD RD MUNCIE 47304	IM	062	MORIARTY, JOHN, ROBT, 6130 SMOCK DR INDIANAPOLIS 46227	FP	134

MORRICAL,DAVID,L, 1201 MICHIGAN AVE LOGANSPOET 46947	IM	030	MOSEK,ROLLIN,HENRY, 105 1ST ST BELLEAIR BEACH FL 33540	GE	134
MORRICAL,RUSSELL,J, 5 CHASE PARK LOGANSPOET 46947	GP	030	MOSES,ROBT,EARL, WORTHINGTON 47471	GP	102
MORRIS,ROBT,ALLEN, 1309 PARK RD ANDERSON 46011	PD	186	MOSS,BOBBY,LEE, 5310 E 16TH ST INDIANAPOLIS 46218	GP	134
MORRIS,ROBT,LYLE, 729 WEST 6TH STREET SEYMOUR 47274	Dk	138	MOSS,HARLAN,B, 1640 N RITTER AVE INDIANAPOLIS 46218	GS	134
MORRIS,WARREN,VICTOR, 115 W MARION ST MONTICELLO 47960	GP	322	MOSS,HERSCHEL,C, 1564 N DOWNEY AVE INDIANAPOLIS 46219	GS	134
MORRIS,WM,HAROLD, 7905 CALUMET AVE MUNSTER 46321	PD	174	MOSWIN,JACK,ARTHUR, 7863 BROADWAY MERRILLVILLE 46410	OBG	174
MORRISON,GEO,GORDON, 209 4TH ST LAWRENCEBURG 47025	GP	050	MOTHERSILL,MARK,HENRY, 3650 N COLLEGE AVE INDIANAPOLIS 46205	A	134
MORRISON,JAMES,TREVOR, 207 N FRANKLIN ST GREENSBURG 47240	GP	054	MOULTON,LILLIAN,G, 1 N BARKER AVE EVANSVILLE 47712	CHP	296
MORRISON,LEWIS,E, I U MED CTR RILEY HOSP A56 INDIANAPOLIS 46202	PS	134	MOUNT,JAMES,LEE, 2900 W 16TH ST BEDFORD 47421	OBG	182
MORROW,ROBT,JACKSON, 1317 L ST BEDFORD 47421	GP	182	MOUNT,MATHIAS,SAML, 148 S LEWIS ST BLOOMFIELD 47424	GP	102
MORSE,ROBT,PETER, 5316 E 16TH ST INDIANAPOLIS 46218	GP	134	MOUNT,WM,MAXWELL, 20 N 24TH ST LAFAYETTE 47904	A	286
MORTENSON,LELAND,JAMES, 1310 W FOSTER PARKWAY FORT WAYNE 46807	GP	082	MOUNTAIN,FRANCIS,B, 930 CENTRAL AVE CONNERSVILLE 47331	IM	074
MORTON,JOS,LEWIS, 3272 W 42ND ST INDIANAPOLIS 46208	TR	134	MOUSER,ROBT,WINSTON, 6201 N PARK AVE INDIANAPOLIS 46220	GP	134
MORTON,PHILIP,MONROE, 4475 SYLVAN RD INDIANAPOLIS 46208	P	134	MUDD,JOS,PAUL, 815 EASTERN BLVD CLARKSVILLE 47130	GP	034
MORTON,WALTER,PHILLIPS, IND NATL BANK TRUST DEPT INDIANAPOLIS 46205	U	134	MUDRONY-SZOKO,JENO,B, 303 S MAIN ST BLUFFTON 46714	R	318
MORTON,WM,MORGAN, 420 W WASHINGTON ST MUNCIE 47305	IM	062	MUELLER,EDWIN,C, 901 I ST LA PORTE 46350	GS	178
MOSBAUGH,PHILLIP,GEO, 2020 W 86TH ST INDIANAPOLIS 46260	U	134	MUELLER,HILBERT,MARTIN, 211 N EDDY AT COLFAX SOUTH BEND 46617	D	258
MOSER,ARTHUR,LEE, 600 E WINONA AVE WARSAW 46580	GP	166	MUELLER,LAWRENCE,W, 533 W WASHINGTON BLVD FORT WAYNE 46802	OPH	082

UFTI, ZAHIR-UL-HAQUE, 321 WEST 20TH ST CONNERSVILLE 47331	IM	074	MUSNGI, LUCIANO, PESTANAS, 102 S MAIN PENDLETON 46064	GP	186
UHLER, JOSEPH, CHARLES, 3217 LAKE AVE FORT WAYNE 46805	FP	082	MUSSELMAN, LAURENCE, K, 500 WABASH AVE MARION 46952	P	098
UKHTAR, FUAD, A, 1202 N LUBIANON ST LEBANON 46052	GS	022	MUSSELMAN, ROBT, H, 3610 BROOKLYN AVE FORT WAYNE 46809	FP	082
ULFORD, ROBT, HARRY, 128 NORTH MAIN ST VERSAILLES 47042		150	MYERS, CHAS, WESLEY, 3350 SALT LAKE RD INDIANAPOLIS 46224	OS	134
ULLER, LULLUS, PETER, 5675 WASHINGTON BLVD INDIANAPOLIS 46220	GS	134	MYERS, GERALD, PAUL, 3123 MISHAWAKA AVE SOUTH BEND 46615	FP	258
ULLER, PAUL, FREDERICK, ST VINCENTS HOSP INDIANAPOLIS 46260	OBG	134	MYERS, JERKY, RICHARD, 110 LAKEVIEW DRIVE NOBLESVILLE 46060	OPH	106
ULLER, VICTOR, H, 2859 N MERIDIAN INDIANAPOLIS 46208	PTH	134	MYERS, PHILIP, ROBT, 408 NORTH SHORE DR EAGLE LAKE EDWARDSBURG MI 49112	OS	258
ULLICAN, WM, STANLEY, 515 READ ST EVANSVILLE 47710	CD	296	MYERS, RONALD, LEE, COMM MENTAL HEALTH CENTER 285 BIELBY ROAD LAWRENCEBURG 47025	P	050
ULLINIX, F, MICHAEL, 1303 NORTH ARLINGTON INDIANAPOLIS 46219		134	MYERS, ROY, VERN, 7710 BETO CIRCLE WEST PALM BEACH FL 33406	OS	134
UNOZ, JOSE, CUI, 5755 ST JOE ROAD FORT WAYNE 46815	PD	082			
			N		
MURALI, MAGARAL, S, 3000 MEADOWS PKWAY INDIANAPOLIS 46205	IM	134	NACHTNEBEL, KENNETH, LOUIS, 611 HARRIET ST EVANSVILLE 47710	GS	296
MURILLO, HERBERT, LAURON, 9512 PRIMROSE MUNSTER 46321	EM	174	NACINO, IRINEO, MONJE, RR 3 BOX 53 SCHNAPF LANE NEWBURGH 47630	AN	296
MURPHY, EDWARD, U, 1015 HULMAN BLDG EVANSVILLE 47708	OPH	296	NAGAN, ROBT, FRANCIS, 555 SOMERSET DR INDIANAPOLIS 46260	GS	134
MURPHY, JOS, FRANCIS, 18225 BURNHAM AVE LANSING IL 60438	P	174	NAKAMURA, TAKAMITSU, 7905 CALUMET MUNSTER 46321	OTO	174
MURPHY, JOSEPHINE, F, 505 W LA SALLE SOUTH BEND 46601	GP	258	NALE, STEPHEN, WAYNE, 1000 EAST SPRING ST NEW ALBANY 47150	FP	078
MURRAY, ERNEST, C, 2200 S WEBSTER ST KOKOMO 46901	IM	126	NALLEY, JAMES, HARRY, R R 3 BOX 198C FRANKLIN 46131	AN	158
MURRAY, JOHN, SUMNER, 118 NORTH 2ND ST VINCENNES 47591		162	NAPPER, KARL, FRANK, 604 N MICHIGAN SOUTH BEND 46601	AN	258
MURRAY, RAYMOND, HAROLD, 2252 BLUEGRASS DR INDIANAPOLIS 46208	IM	134	NASR, AMIN, TOUFIC, 2401 RIGGIN RD MUNCIE 47304	PTH	146

NASSER,WM,KALEEL, 5420 GRANDVIEW DR INDIANAPOLIS 46208	CD	134	NELSON,JAMES,BERT, 3030 LAKE AVE FURT WAYNE 46825	A	082
NAVARRO,ALFONSO,V, 46 STONEGATE DR STONEGATE PROFESSIONAL PLAZA INDIANAPOLIS 46227	IM	158	NELSON,WALFRED,ARTHUR, 559 S LAKE ST GARY 46403	GP	174
NAVARRO,CASIMIRO,PERALTA, 1725 EAST 56TH ST INDIANAPOLIS 46220	OS	134	NESBIT,LEONARD,LOCKE, 50 RIVER FOREST ANDERSON 46011	OPH	186
NAY,RICHARD,MARION, 3524 N MERIDIAN INDIANAPOLIS 46208	IM	134	NESTER,HENRY,G, 5324 N PENNSYLVANIA ST INDIANAPOLIS 46220	PH	134
NAZON,YVON, 504 BROADWAY SUITE 1025 GARY 46402	OBG	174	NEUDORFF,LOUIS,GEO, 221 S 6TH ST TERRE HAUTE 47801	IM	296
NEAL,LEONARD,WILSON, 1000 AZALEA DRIVE MUNSTER 46321	FP	174	NEUKAMP,FRANK,H, 611 LAS PALMAS SANTA BARBARA CA 93110	GP	074
NEALE,ALFRED,EUGENE, 1931 BROWN ST ANDERSON 46014		186	NEWBY,H,EUGENE, 201 W 4TH ST SHERIDAN 46069	GP	106
NEDELKOFF,BOGDAN, RD 2 BOX 504H NEW ALBANY 47150	PTH	076	NEWCOMB,WM,KENDALL, BOX 158 ROYAL CENTER 46978	GP	030
NEED,DAVID,JOHN, 7150 MADISON AVE INDIANAPOLIS 46227	PD	134	NEWMAN,ALVIN,EDWARD, 2937 CORAL SHORES DR FORT LAUDERDALE FL 33306	OS	296
NEED,LOUIS,T, 3627 BLUFF RD INDIANAPOLIS 46217	GP	134	NEWMAN,DANL,MARQUETTE, 1711 N CAPITAL AVE INDIANAPOLIS 46202	U	134
NEED,RICHARD,LOUIS, 4949 CARSON AVE INDIANAPOLIS 46227	IM	134	NEWMAN,KERRY,JUN, 540 AUDUBON DR EVANSVILLE 47715	IM	296
NEER,DAVID,DREW, 7550 HOHMAN AVE STE 300 MUNSTER 46321	N	174	NEWNAM,PHILIP,EDWARD, 420 W WASHINGTON MUNCIE 47305	IM	062
NEHER,JOHN,LEWIS, 17615 STATE RD 23 SOUTH BEND 46635	GP	258	NEWNUM,RAYMOND,L, 801 ST MARYS DR NC 309 EVANSVILLE 47715	IM	296
NEIFERT,NOEL,L, PROFESSIONAL REALTY BLDG TELL CITY 47586	GP	222	NEWSOME,COLA,KING, 415 E MULBERRY ST EVANSVILLE 47713	GP	296
NELSON,BRYAN,EDWARD, 2760 25TH ST COLUMBUS 47201	GP	014	NEWTON,ROGER,EUGENE, 1400 LARK LANE EVANSVILLE 47708	OBG	296
NELSON,CARL,ALBERT, P O BOX 278 WEST LEBANON 47991	GP	086	NG,ANASTACIO,C, 8927 SPICEWOOD RD INDIANAPOLIS 46260	R	134
NELSON,DELBERT,WM, 303 SOUTH MAIN ST BLUFFTON 46714	GP	318	NICE,WM,ARCHIE, R R NO 11 BOX 309-J BLOOMINGTON 47401	GP	214
NELSON,FRANCIS,DALE, 1951 E FOX ST SOUTH BEND 46613	FP	258	NICELY,PAULETTE,ANN G, 7209 SYLVAN RIDGE RD INDIANAPOLIS 46240		134

NICHOLAS,DENNIS,J, 5300 FARHILL RD INDIANAPOLIS 46226	AN	134	NOROOZI,IRADJ, 16 FAIRWAY DR TERRE HAUTE 47802	OBG	298
NICHOLAS,THOS,DAVID, ROCKVILLE TOWN SQUARE CLINIC ROCKVILLE 47872		218	NORRIS,MAX,S, 3266 N MERIDIAN APT 604 INDIANAPOLIS 46208	IM	134
NICHOLS,HAROLD,GENE, 711 EAST COLFAX AVE SOUTH BEND 46617	P	258	NORTON,HORACE, 325 KNOLLWOOD WASHINGTON 47501	GP	046
NICHOLSON,RAYMOND,WM, 801 ST MARYS DRIVE SUITE 200 EVANSVILLE 47715	FP	296	NOURSE,MYRON,H, 1711 N CAPITOL AVE INDIANAPOLIS 46202	U	134
NICOSIA,JOHN,B, 1802 COLUMBUS DR EAST CHICAGO 46312	GP	174	NOVEROSKE,RICHARD,JOHN, 3901 LINCOLN EVANSVILLE 47715	K	296
NIE,LOUIS,WM, 3231 N MERIDIAN ST INDIANAPOLIS 46208	P	134	NOVY,CHAS,AUGUST, 615 W DENNIS ST GARRETT 46738	GP	058
NIEDERMAYER,ALFRED,JOS, 960 WASHINGTON AVE EVANSVILLE 47713	EM	296	NUTTER,WYNDHAM,HUNT, 1003 N MORGAN ST RUSHVILLE 46173	GP	254
NIKSCH,WM,LOUIS, 1005 CAMPBELL ST VALPARAISO 46383	FP	230	NUVAL,AUGUSTO,JOSE, 7318 PRINCE DR R R 22 BOX 667 TERRE HAUTE 47802	AN	298
NILL,JOHN,HENRY, 5717 S ANTHONY BLVD FORT WAYNE 46806	GP	082			
NOE,WM,ROBT, 380 ASPEN DRIVE CARMEL 46032	GS	182	O'BRIAN,EARL,J, 3500 LAFAYETTE RD INDIANAPOLIS 46222	FP	134
NOFZIGER,TERRY,LEE, R R 2 PAOLI 47454	FP	210	O'BRIAN,JOHN,FRANCIS, 3217 LAKE AVE FORT WAYNE 46805	FP	082
NOHL,JOHN,MARTIN, 457 N EMERSON AVE INDIANAPOLIS 46219	GP	134	O'BRIEN,DAVID,MICHAEL, 2400 E 17TH ST COLUMBUS 47201	PTH	014
NOLAN,GERALD,ROBT, 5717 S ANTHONY BLVD FORT WAYNE 46806	FP	082	O'BRIEN,FRANCIS,EUGENE, WASHINGTON ST RENSSELAER 47978	FP	142
MONTE,LEO,ROBT, DR PLAZA-611 HARRIET ST EVANSVILLE 47710	GS	296	O'BRIEN,RAYMOND,J, 1601 FRANKLIN ST MICHIGAN CITY 46360	ORS	178
NORBORG,CHRISTOPHER,S, 515 NORTH LAFAYETTE SOUTH BEND 46601	OBG	258	O'BRYAN,RICHARD,BRUCE, 2739 CENTRAL AVE COLUMBUS 47201	PD	014
NORDSCHOW,CARLETON,D, 1100 W MICHIGAN ST INDIANAPOLIS 46202	CLP	134	O'DONOVAN,CORNELIUS,J, MILES LABS INC ELKHART 46514	IM	070
NORINS,ARTHUR,LEONARD, 1100 W MICHIGAN INDIANAPOLIS 46202	D	134	O'NEILL,MARTIN,JAMES, 301 WASHINGTON ST VALPARAISO 46383	OS	230
NORMAN,WILLIAM,H, 115 N PENNSYLVANIA ST RM 1252 INDIANAPOLIS 46204	ORS	134	O'ROURKE,CARROLL, 604 W BERRY ST FORT WAYNE 46802	OPH	082

OCA, CLEMENTE, FERNANDEZ, 207 SPARKS AVE JEFFERSONVILLE 47130	CD	034	ONG, TIONG, GIOK, 1005 N CAMPBELL ST VALPARAISO 46383	GP	230
OCHSNER, EDWARD, C, GREENWOOD RADIOLOGY 622 N MADISON AVE GREENWOOD 46142	DK	118	ONORATO, JOS, J, 2433 S 9TH ST LAFAYETTE 47905	IM	280
OCHSNER, HAROLD, CONRAD, 5850 SUNSET LANE INDIANAPOLIS 46260	R	134	ONYETT, HAROLD, R, P O BOX 358 GREENWOOD 46142	GP	134
ODRUCIC, KAZIMIR, JURAJ, 211 N EDDY SOUTH BEND 46617	OPH	258	OPPENHEIM, BERNAKD, E, 2023 WHITEWOOD COURT INDIANAPOLIS 46260	NM	134
ODULIO, BENITO, V, 121 6TH ST MITCHELL 47446	GS	182	ORNELAS, JOS, PAUL, 6111 HARRISON ST MERRILLVILLE 46410	A	174
ODULIO, BRUNHILDA, IRIS, HWY 60 EAST RFD 2 MITCHELL 47446	IM	182	ORR, W, ROBERT, 12388 EAST JEFFERSON RD MISHAWAKA 46544	ORS	258
OEHLER, NANCY, LEE MARTIN, 725 S FOREST AVE BRAZIL 47834	PM	038	OSBOKNE, JOHN, V, 420 W WASHINGTON ST MUNCIE 47305	GS	062
OEHLER, ROBT, CURTIS, 725 SOUTH FOREST AVE BRAZIL 47834	IM	038	OSTER, JACK, H, 1909 BEECH ST VALPARAISO 46383	P	230
OEI, TJIEN, DEN, 1100 WEST MICHIGAN ST INDIANAPOLIS 46202	PTH	134	OSTHEIMER, GEO, JAMES, SUNNYSIDE DR BOX 23 MARTINSVILLE 46151	GP	202
OFFUTT, ANDREW, CARROLL, 750 N CAMPBELL AVE INDIANAPOLIS 46219	PH	134	OSWALD, ROBT, HAROLD, 326 S E 7TH ST EVANSVILLE 47713	OBG	296
OGLE, ROBT, WAYNE, 622 NORTH MADISON AVE GREENWOOD 46142	GP	158	OSWALT, JAMES, TELFER, 2900 W 16TH ST BEDFORD 47421		182
OLDAG, GEO, EDWARD, 1402 SOUTH F ELWOOD 46036	GS	186	OVERLEY, TONER, MORTON, 8333 N ILLINOIS ST INDIANAPOLIS IN 46260	P	134
OLSON, DONALD, T, 919 E JEFFERSON BLVD SOUTH BEND 46622	CD	258	OVERPECK, GEO, H, RR 4 BOX 275 ALEXANDRIA 46001	GP	186
OLSON, KENNETH, L, 919 E JEFFERSON BLVD SOUTH BEND 46622	R	258	OWEN, HUGH, THOS, 207 SPARKS AVE JEFFERSONVILLE 47130	D	296
OLSON, L, DALE, VALPARAISO ORTHOPEDIC CLINIC 2501 CUMBERLAND DR VALPARAISO 46383	ORS	230	OWEN, JOHN, ELBA, 11329 ROLLING SPRING DR CARMEL 46032	GS	134
OLVEY, OTTIS, NIEL, 420 W KESSLER BLVD INDIANAPOLIS 46208	IM	134	OWEN, THOS, FREDRIC, 313 N HARRISON ST ALEXANDRIA 46001	GP	186
OMSTEAD, MILTON, HARVEY, 110 S 6TH ST PETERSBURG 47567	GP	226	OWENS, TRACY, CLIFTON, 2211A ROME DR INDIANAPOLIS 46208	P	134
			OWENS, WALTER, LEE, 421 W 1ST ST BLOOMINGTON 47401	OBG	214

OWSLEY,GUY,ARGYLE, 214 N HIGH ST HARTFORD CITY 47348	OTO	062	PANOST,VERNON,K, 1000 W MARION ST ELKHART 46514	GP	070
			PANGAN,ZANITA,S, 802 LA PORTE VALPARAISO 46383	OBG	230
P					
PAFF,JAMES,RICHARD, 3308 SUSAN DRIVE KOKOMO 46901	PTH	062	PANOS,CONSTANTINE,GEO, 227 S MAIN ST BLUFFTON 46714	GP	318
PAFF,WM,ALFRED, 1509 MEADOW LN ELKHART 46514	IM	070	PANSZI,JOSE,G, 2724 WEST NORTH ST MUNCIE 47304	N	062
PAIK,BO,WOOK, 303 S MAIN ST MISHAWAKA 46544	IM	258	PANTZER,JOHN,GEO, 1815 N CAPITOL AVE NO 312 INDIANAPOLIS 46202	PS	134
PAIK,GUN,SIL, 1225 COOLSPRING AVE MICHIGAN CITY 46360	OBG	178	PAPADOPOULOS,A,P, 2200 CALIFORNIA ROAD ELKHART 46514	ORS	070
PAINE,GEO,ELSNER, 329 MEISNER ST ELKHART 46514	AN	070	PAPPAS,EDDIE,THOS, 6429 ARTHUR ST MERRILLVILLE 46410	GP	174
PAINTER,DONALD,SCOTT, 220 MED CTR BLDG FORT WAYNE 46802	OBG	082	PARAISO,ANTONIO,QUEVEDO, 830 SIM HODGIN PKWY RICHMOND 47374	OBG	314
PAINTER,LOWELL,WALTER, 124 E FRANKLIN ST WINCHESTER 47394	ABS	246	PARAS,JOSE,LINGKOD JUANE, BATESVILLE IN 47006	GP	250
PAIRITZ,FRANK,DAVID, 919 E JEFFERSON BLVD SOUTH BEND 46622	R	258	PARIS,DURWARD,WHITEMAN, 614 ARMSTRONG KOKOMO 46901	IM	126
PALMER,BARRON,M F, 6134 COLUMBIA AVE HAMMOND 46320		174	PARIS,JOHN,MERRILL, 1919 STATE ST STE 321 NEW ALBANY 47150	FP	078
PALMER,HARLEY,PERRY, 1500 N RITTER PATHOLOGY DEPT INDIANAPOLIS 46219	CLP	158	PARK,BYRON,J, 1250 CHESTER BLVD RICHMOND 47374	ORS	314
PALMER,ROBERT,M, 2020 W 86TH ST SUITE 305 INDIANAPOLIS 46260	ORS	134	PARK,HEE,MYUNG, 3102 LEHIGH COURT INDIANAPOLIS 46268	NM	134
PALMER,ROBT,W, 5626 EAST 16TH ST INDIANAPOLIS 46218	IM	134	PARK,JASON,Y S, 7619 MONTICELLO DR TERRE HAUTE 47802	P	298
PAMINTUAN,FLORINDO,GANDO, 7905 CALUMET AVE MUNSTER 46321	CD	174	PARKE,WM,COULTER, 2335 DUBOIS DR WARSAW 46580	GP	166
PAN,CHAS,CHIEH-MING, 700 BROADWAY FORT WAYNE 46802	PTH	082	PARKER,E,CAMILLE KILLIAN, 2500 E BROADWAY LOGANSPORT 46947	OPH	030
PANCHOLY,NAVIN,CHIMANLAL, 1025 MANCHESTER WABASH 46992	GS	302	PARKER,FRANCIS,WM, 2500 E BROADWAY LOGANSPORT 46947	OPH	030
PANCNER,RONALD,JERRY, 1812 FORT WAYNE NATL BANK BLDG FORT WAYNE 46802	P	082	PARKER,GEO,FRANCIS, 1502 NORTH EMERSON INDIANAPOLIS 46219	PDA	134

PARKER, JOHN, CARL, BOX 298 GOODLAND 47948	GP	204	PATEL, RASHMI, CHIMANLAL, 7550 HOHMAN AVE MUNSTER 46321	GS	174
PARKER, JOHN, FRANCIS, 5165 E PLEASANT RUN PKWY INDIANAPOLIS 46219	GP	134	PATEL, UPENDRA, H, 7550 HOHMAN AVE MUNSTER 46321	ORS	174
PARKS, GEO, OAKS, 720 N SPRING ST HARTFORD CITY 47348	GP	062	PATHEJA, SURJIT, SINGH, 4001 SLEIGHBELL CT VALPARAISO 46383	OK	230
PARKS, HERBERT, EUGENE, 5533 OVERBROOK CIRCLE INDIANAPOLIS 46219	R	134	PATRON, LEONARDO, A, 306 BINFORD ST CULVER HOSPITAL CRAWFORDSVILLE 47933	AN	198
PARMENTER, HARRY, B, 502 AMERICAN BANK BLDG VINCENNES 47591	AN	162	PATTERSON, JACK, WALTER, 6211 COVINGTON RD FORT WAYNE 46804	GS	082
PARR, ROBT, LOWELL, 5430 E 21ST ST INDIANAPOLIS 46218	PD	134	PATTERSON, WM, K, 8 S PARK DR ANDERSON 46011	AN	186
PARRATT, LOUIS, WARDROP, 504 BROADWAY GARY 46402	GP	174	PATTISON, JOHN, DAVID, 131 N WASHINGTON ST MARION 46952	IM	098
PARRISH, RICHARD, K, 238 S 2D ST DECATUR 46733	UPH	010	PATTON, CHAS, NATHAN, 1001 LIFE BLDG LAFAYETTE 47901	AN	286
PARROT, DONALD, JEROME, 810 W STATE ST FORT WAYNE 46808	GP	082	PAUL, EUELL, GEO, 7550 HOHMAN AVE MUNSTER 46321	GS	174
PARSHALL, DALE, BRYAN, ELKHART GEN HOSP ELKHART 46514	R	070	PAUSZEK, ROBT, BRUCE, 6419 JOHNSON ROAD INDIANAPOLIS 46220	PD	134
PARSONS, ROBT, LA RUE, 919 E JEFFERSON BLVD SOUTH BEND 46622	ORS	258	PAUSZEK, THOS, B, 916 RIVERSIDE DR SOUTH BEND 46616	OBG	258
PASALICH, JOHN, NOVAK, 6211 COVINGTON ROAD FORT WAYNE 46804	R	082	PAVELKA, RONALD, PETER, 7905 CALUMET MUNSTER 46321	ORS	174
PASCUZZI, CHRIS, A, 531 N MAIN ST SOUTH BEND 46601	PTH	258	PAVLICK, THEODORE, JOS, 1001 WALNUT ST EVANSVILLE 47713	UPH	296
PASILABBAN-BANGUIS, L, M, 103 W WASHINGTON ST SHELBYVILLE 46176	IM	266	PAYNE, ARTHUR, C, 2020 BROADWAY EAST CHICAGO 46312	GP	174
PASTOR, JULIUS, WM, 5901 WASHINGTON AVE EVANSVILLE 47715	AN	296	PAYNTER, MORRIS, BURTON, 115 WHITE HORSE LIV NOBLESVILLE 46060	GP	134
PATEL, MANUBHAI, P, COUNTRY CLUB HILLS R R 3 KENDALLVILLE 46755	GS	206	PAYNTER, WM, T, 1330 W MICHIGAN ST INDIANAPOLIS 46206	P	134
PATEL, PULKIT, JOITARAM, 7003 WILLIAMSBURG LN TERRE HAUTE 47802	U	298	PAZ, LUIS, AUGUSTO, 1007 N 16TH ST NEW CASTLE 47362	U	122
PATEL, RAMESHCHANDRA, I, KEM VIEW MEDICAL CENTER 1251 KEM ROAD MARION 46952	PD	098	PEACOCK, NORMAN, F, 219 BEN HUR BLDG CRAWFORDSVILLE 47933	OTO	198

PEACOCK,ROBT,COWDEN, 2724 W NORTH ST MUNCIE 47303	U	062	PELL,DONALD,MC LAURY, 3729 WEST JACKSON ST MUNCIE 47304	IM	062
PEARCE,ROBT,MICHAEL, 5430 EAST 21ST ST INDIANAPOLIS 46218	P	134	PEMBERTON,JACK,JAMES, 611 HARRIET EVANSVILLE 47710	GP	296
PEARCE,ROY,VOYLES, 1440 S 25TH ST TERRE HAUTE 47803	GP	298	PENKAVA,ROBT,RAY, 611 HARRIET ST EVANSVILLE 47715	DR	296
PEARCY,MARCENE, P O BOX 987 MARION 46952	U	096	PENN,ROBT,ALLAN, 3620 CENTRAL AVE EAST GARY 46405	GP	174
PEARE,REEVE,BURTON, MEDICAL ARTS BLDG 1255 ENGLE ST HUNTINGTON 46750	GP	130	PERALTA,JOSE, 411 TINSLEY AVE CRAWFORDSVILLE 47933	GS	198
PEARSON,HUEY,LAWRENCE, 2314 S HANNA ST FORT WAYNE 46803	GP	082	PERCINEL,AHMET,KEMAL, 801 ST MARYS DR EVANSVILLE 47715	HS	296
PEARSON,JACK,WILLARD, 11715 EDEN GLEN DR CARMEL 46032	OBG	134	PEREZ,CESAR,EUELBERTO, P O BOX 622 CARMEL 46032	AN	134
PEARSON,JOHN,STROTHER, ONE WEST 26TH ST INDIANAPOLIS 46206	OM	134	PERKINS,POWELL,LEON, 317 S BERKLEY ST KOKOMO 46901	GS	126
PEARSON,LYMAN,REES, 632 EDGEWATER DR 431 DUNEDIN FL 33528	CRS	134	PERRIN,KERMIT,FLOYD, 2701 S ANTHONY BLVD FORT WAYNE 46806	GP	082
PEARSON,WM,EPHRIUM, 290 N WABASH ST WABASH 46992	GP	302	PERRIN,NELLJEAN, 10412 HOLIDAY DRIVE CARMEL 46032	PD	134
PECK,FRANKLIN,B, 8181 LINCOLN BLVD INDIANAPOLIS 46240	IM	134	PERRY,GUY,FELAND, 605 COTTAGE COHA COLUMBUS 47201	OM	014
PECK,FRANKLIN,BRUCE, 5858 W LAZY S TUCSON AZ 85713	IM	134	PERSON,THEODORE,C, 601 N MILL ST VEEDERSBURG 47987	GP	086
PECK,JAMES,FRANK, 302 N PRINCE ST PRINCETON IN 47670	GP	094	PESARILLO,SERVANDO,N, 401 E REYNOLDS KOKOMO 46901	GP	126
PEDDICORD,CLIFFORD,R, R R 3 RENSSELAER 47978	DR	030	PESIGAN,CONRADO,SION, 116 SOUTH DELPHIA PARK RIDGE IL 60068	R	174
PEDEN,EMMA,JANE, 1303 N ARLINGTON INDIANAPOLIS 46219	IM	134	PETERS,ELMER,E, 830 MAIN ST BROOKVILLE 47012	GP	074
PEDUK,MARIA,A, EVANSVILLE STATE HOSP EVANSVILLE 47715	GP	296	PETERSON,DEWARD,D, 221 S 6TH ST TERRE HAUTE 47801	R	296
PEIFFER,GERALDINE,M, ST MARGARET HOSP HAMMOND 46320	AN	174	PETERSON,JAMES,ARTHUR, ELKHART CLINIC BOX 2507 ELKHART 46514	PD	070
PEIRCE,JAMES,D, 5027 WASHINGTON BLVD INDIANAPOLIS 46205	OM	134	PETERSON,RONALD,L, 116 E WASHINGTON ST PLYMOUTH 46563	FP	190

PETITJEAN, HAROLD, GEO, R D 2 HAUBSTADT IN 47639	FP	094	PHILLIPS, JOHN, HARMON, 1511 WABASH ST MICHIGAN CITY 46360	GP	178
PETRANOFF, THEODORE, V, 2814 QUESTEND S DR INDIANAPOLIS 46222	GP	134	PHIPPS, LELAND, K, R R 1 BOX 73 UNION CITY 47390	GP	246
PETRASS, ANDREW, 22027 LIBERTY HWY SOUTH BEND 46601	GP	258	PHITHAYANUKARN, JOSEFINA, P O BOX 102 WESTVILLE 46391		174
PETRICH, PETER, RICHARD, 401 S PERRY ST ATTICA 47918	GP	086	PICKETT, MERLE, ELMER, 5800 FAIRFIELD AVE FORT WAYNE 46807	AN	082
PETRIN, THOS, JOHN, 7005 GROSVENOR PLACE INDIANAPOLIS 46208	IM	134	PICKETT, ROBT, D, 3524 N MERIDIAN ST INDIANAPOLIS 46208	IM	134
PETRY, THOS, NEAL, 110 S UNION ST DELPHI 46923	GP	026	PIERCE, EMMETT, C, BOX 706 GREENFIELD 46140	PTH	134
PETTIS, ARTHUR, GLASCO, METHODIST HOSP GARY 46402	AN	174	PIERCE, GENE, STRATTON, 112 PROF ARTS BLDG-1919 STATE NEW ALBANY 47150	FP	078
PEYTON, FRANK, WOOD, 2400 FERRY ST LAFAYETTE 47904	OBG	280	PIERCE, WM, J, DIAGNOSTIC CYTO CLINIC BRUCEVILLE 47516	PTH	046
PFAFF, DUDLEY, A, 25 EAST 40TH ST APT 5-D INDIANAPOLIS 46205	GYN	134	PIETZ, DAVID, GEO, 303 S MAIN ST BLUFFTON 46714	GE	318
PFEIFER, JAMES, MORRIS, 319 FRONT ST LAWRENCEBURG 47025	IM	050	PILE, STAFFORD, WALLACE, 8109 BRAMWOOD COURT INDIANAPOLIS 46250	U	134
PFROMMER, JOHN, R, 2600 GREENBUSH ST LAFAYETTE 47904	AM	286	PILECKI, PETER, J, 1225 E COOLSPRING AVE MICHIGAN CITY 46360	GP	178
PFUETZE, MAX, ENSIGN, 408 NORTH ST LOGANSPOUT 46947	OM	030	PILLAI, VIJAYAN, V, DUNN MEMORIAL HOSP BEDFORD 47421	GS	182
PHARES, ROBT, WESLEY, 1712 S MALFALFA RD KOKOMO 46901	AN	126	PILLAY, VIJAYAPRASANTHAN, 1000 EAST 80TH ST SUITE 525 MERRILLVILLE 46410	NS	174
PHELPS, JAMES, MICHAEL, 4425 N 250 W WEST LAFAYETTE 47906	R	286	PILOT, JEAN, 7137 KNICKERBOCKER HAMMOND 46323	PTH	174
PHELPS, STEPHEN, ROWLES, 808 SHERLAND BLDG SOUTH BEND 46601	D	258	PIPPENGER, JOS, IRWIN, 310 W JACKSON ST MUNCIE 47305	GP	062
PHILBROOK, SETH, S, 705 HARRISON ST LA PORTE 46350	OPH	178	PIPPENGER, WAYNE, GRISE, 1 WESTWOOD DR FRANKFORT 46041	GP	042
PHILLIPS, DAVID, LEE, 3561 N PENNSYLVANIA INDIANAPOLIS 46205	P	134	PITTMAN, JOHN, NORMAN, 201 W 106TH ST INDIANAPOLIS 46290	CDS	134
PHILLIPS, DONALD, MICHAEL, 1356 S LAKE PARK HOBART 46342	GP	174	PITTS, NEAL, CHASE, 303 S MAIN ST BLUFFTON 46714	RHU	318

UFTI, ZAHIR-UL-HAQUE, 321 WEST 20TH ST CONNERSVILLE 47331	IM	074	MUSNGI, LUCIANO, PESTANAS, 102 S MAIN PENDLETON 46064	GP	186
UHLER, JOSEPH, CHARLES, 3217 LAKE AVE FORT WAYNE 46805	FP	082	MUSSELMAN, LAURENCE, K, 500 WABASH AVE MARION 46952	P	098
UKHTAR, FUAD, A, 1202 N LUBIANON ST LEBANON 46052	GS	022	MUSSELMAN, ROBT, H, 3610 BROOKLYN AVE FORT WAYNE 46809	FP	082
ULFORD, ROBT, HARRY, 128 NORTH MAIN ST VERSAILLES 47042		150	MYERS, CHAS, WESLEY, 3350 SALT LAKE RD INDIANAPOLIS 46224	OS	134
ULLER, LULLUS, PETER, 5675 WASHINGTON BLVD INDIANAPOLIS 46220	GS	134	MYERS, GERALD, PAUL, 3123 MISHAWAKA AVE SOUTH BEND 46615	FP	258
ULLER, PAUL, FREDERICK, ST VINCENTS HOSP INDIANAPOLIS 46260	OBG	134	MYERS, JERRY, RICHARD, 110 LAKEVIEW DRIVE NOBLESVILLE 46060	OPH	106
ULLER, VICTOR, H, 2859 N MERIDIAN INDIANAPOLIS 46208	PTH	134	MYERS, PHILIP, ROBT, 408 NORTH SHORE DR EAGLE LAKE EDWARDSBURG MI 49112	OS	258
ULLICAN, WM, STANLEY, 515 READ ST EVANSVILLE 47710	CD	296	MYERS, RONALD, LEE, COMM MENTAL HEALTH CENTER 285 BIELBY ROAD LAWRENCEBURG 47025	P	050
ULLINIX, F, MICHAEL, 1303 NORTH ARLINGTON INDIANAPOLIS 46219		134	MYERS, ROY, VERN, 7710 BETO CIRCLE WEST PALM BEACH FL 33406	OS	134
UNOZ, JOSE, CUI, 5755 ST JOE ROAD FORT WAYNE 46815	PD	082			
			N		
URALI, MAGARAL, S, 3000 MEADOWS PKWAY INDIANAPOLIS 46205	IM	134	NACHTNEBEL, KENNETH, LOUIS, 611 HARRIET ST EVANSVILLE 47710	GS	296
URILLO, HERBERT, LAURON, 9512 PRIMROSE MUNSTER 46321	EM	174	NACINO, IRINEO, MONJE, RR 3 BOX 53 SCHNAPF LANE NEWBURGH 47630	AN	296
MURPHY, EDWARD, U, 1015 HULMAN BLDG EVANSVILLE 47708	OPH	296	NAGAN, ROBT, FRANCIS, 555 SOMERSET DR INDIANAPOLIS 46260	GS	134
MURPHY, JOS, FRANCIS, 18225 BURNHAM AVE LANSING IL 60438	P	174	NAKAMURA, TAKAMITSU, 7905 CALUMET MUNSTER 46321	OTO	174
MURPHY, JOSEPHINE, F, 505 W LA SALLE SOUTH BEND 46601	GP	258	NALE, STEPHEN, WAYNE, 1000 EAST SPRING ST NEW ALBANY 47150	FP	078
MURRAY, ERNEST, C, 2200 S WEBSTER ST KOKOMO 46901	IM	126	NALLEY, JAMES, HARRY, R R 3 BOX 198C FRANKLIN 46131	AN	158
MURRAY, JOHN, SUMNER, 118 NORTH 2ND ST VINCENNES 47591		162	NAPPER, KARL, FRANK, 604 N MICHIGAN SOUTH BEND 46601	AN	258
MURRAY, RAYMOND, HAROLD, 2252 BLUEGRASS DR INDIANAPOLIS 46208	IM	134	NASR, AMIN, TOUFIC, 2401 RIGGIN RD MUNCIE 47304	PTH	146

NASSER,WM,KALEEL, 5420 GRANDVIEW DR INDIANAPOLIS 46208	CD	134	NELSON,JAMES,BERT, 3030 LAKE AVE FORT WAYNE 46825	A	082
NAVARRO,ALFONSO,V, 46 STONEGATE DR STONEGATE PROFESSIONAL PLAZA INDIANAPOLIS 46227	IM	158	NELSON,WALFRED,ARTHUR, 559 S LAKE ST GARY 46403	GP	174
NAVARRO,CASIMIRO,PERALTA, 1725 EAST 56TH ST INDIANAPOLIS 46220	US	134	NESBIT,LEONARD,LOCKE, 50 RIVER FOREST ANDERSON 46011	OPH	186
NAY,RICHARD,MARION, 3524 N MERIDIAN INDIANAPOLIS 46208	IM	134	NESTER,HENRY,G, 5324 N PENNSYLVANIA ST INDIANAPOLIS 46220	PH	134
NAZON,YVON, 504 BROADWAY SUITE 1025 GARY 46402	OBG	174	NEUDORFF,LOUIS,GEO, 221 S 6TH ST TERRE HAUTE 47801	IM	296
NEAL,LEONARD,WILSON, 1000 AZALEA DRIVE MUNSTER 46321	FP	174	NEUKAMP,FRANK,H, 611 LAS PALMAS SANTA BARBARA CA 93110	GP	074
NEALE,ALFRED,EUGENE, 1931 BROWN ST ANDERSON 46014		186	NEWBY,H,EUGENE, 201 W 4TH ST SHERIDAN 46069	GP	106
NEDELKOFF,BOGDAN, RD 2 BOX 500H NEW ALBANY 47150	PTH	078	NEWCOMB,WM,KENDALL, BOX 158 ROYAL CENTER 46978	GP	030
NEED,DAVID,JOHN, 7150 MADISON AVE INDIANAPOLIS 46227	PD	134	NEWMAN,ALVIN,EDWARD, 2937 COKAL SHORES DR FORT LAUDERDALE FL 33306	OS	296
NEED,LOUIS,T, 3627 BLUFF RD INDIANAPOLIS 46217	GP	134	NEWMAN,DANL,MARQUETTE, 1711 N CAPITAL AVE INDIANAPOLIS 46202	U	134
NEED,RICHARD,LOUIS, 4949 CARSON AVE INDIANAPOLIS 46227	IM	134	NEWMAN,KERRY,JUN, 540 AUDUBON DR EVANSVILLE 47715	IM	296
NEER,DAVID,DREW, 7550 HOHMAN AVE STE 300 MUNSTER 46321	N	174	NEWNAM,PHILIP,EDWARD, 420 W WASHINGTON MUNCIE 47305	IM	062
NEHER,JOHN,LEWIS, 17615 STATE RD 23 SOUTH BEND 46635	GP	258	NEWNUM,RAYMOND,L, 801 ST MARYS DR NC 309 EVANSVILLE 47715	IM	296
NEIFERT,NOEL,L, PROFESSIONAL REALTY BLDG TELL CITY 47586	GP	222	NEWSOME,COLA,KING, 415 E MULBERRY ST EVANSVILLE 47713	GP	296
NELSON,BRYAN,EDWARD, 2760 25TH ST COLUMBUS 47201	GP	014	NEWTON,ROGER,EUGENE, 1400 LARK LANE EVANSVILLE 47708	OBG	296
NELSON,CARL,ALBERT, P O BOX 278 WEST LEBANON 47991	GP	086	NG,ANASTACIO,C, 8927 SPICEWOOD RD INDIANAPOLIS 46260	R	134
NELSON,DELBERT,WM, 303 SOUTH MAIN ST BLUFFTON 46714	GP	318	NICE,WM,ARCHIE, R R NO 11 BOX 309-J BLOOMINGTON 47401	GP	214
NELSON,FRANCIS,DALE, 1951 E FOX ST SOUTH BEND 46613	FP	258	NICELY,PAULETTE,ANN G, 7209 SYLVAN RIDGE RD INDIANAPOLIS 46240		134

NICHOLAS, DENNIS, J, 5300 FARHILL RD INDIANAPOLIS 46226	AN	134	NOROOZI, IRADJ, 16 FAIRWAY DR TERRE HAUTE 47802	OBG	298
NICHOLAS, THOS, DAVID, ROCKVILLE TOWN SQUARE CLINIC ROCKVILLE 47872		218	NORRIS, MAX, S, 3266 N MERIDIAN APT 604 INDIANAPOLIS 46208	IM	134
NICHOLS, HAROLD, GENE, 711 EAST COLFAX AVE SOUTH BEND 46617	P	258	NORTON, HORACE, 325 KNOLLWOOD WASHINGTON 47501	GP	046
NICHOLSON, RAYMOND, WM, 801 ST MARYS DRIVE SUITE 200 EVANSVILLE 47715	FP	296	NOURSE, MYRON, H, 1711 N CAPITOL AVE INDIANAPOLIS 46202	U	134
NICOSIA, JOHN, B, 1802 COLUMBUS DR EAST CHICAGO 46312	GP	174	NOVEROSKE, RICHARD, JOHN, 3901 LINCOLN EVANSVILLE 47715	R	296
NIE, LOUIS, WM, 3231 N MERIDIAN ST INDIANAPOLIS 46208	P	134	NOVY, CHAS, AUGUST, 615 W DENNIS ST GARRETT 46738	GP	058
NIEDERMAYER, ALFRED, JOS, 960 WASHINGTON AVE EVANSVILLE 47713	EM	296	NUTTER, WYNDHAM, HUNT, 1003 N MORGAN ST RUSHVILLE 46173	GP	254
NIKSCH, WM, LOUIS, 1005 CAMPBELL ST VALPARAISO 46383	FP	230	NUVAL, AUGUSTO, JOSE, 7318 PRINCE DR R R 22 BOX 667 TERRE HAUTE 47802	AN	298
NILL, JOHN, HENRY, 5717 S ANTHONY BLVD FORT WAYNE 46806	GP	082			
NOE, WM, ROBT, 380 ASPEN DRIVE CARMEL 46032	GS	182	O'BRIAN, EARL, J, 3500 LAFAYETTE RD INDIANAPOLIS 46222	FP	134
NOFZIGER, TERRY, LEE, R R 2 PAOLI 47454	FP	210	O'BRIAN, JOHN, FRANCIS, 3217 LAKE AVE FORT WAYNE 46805	FP	082
NOHL, JOHN, MARTIN, 457 N EMERSON AVE INDIANAPOLIS 46219	GP	134	O'BRIEN, DAVID, MICHAEL, 2400 E 17TH ST COLUMBUS 47201	PTH	014
NOLAN, GERALD, ROBT, 5717 S ANTHONY BLVD FORT WAYNE 46806	FP	082	O'BRIEN, FRANCIS, EUGENE, WASHINGTON ST RENSSELAER 47978	FP	142
MONTE, LEO, ROBT, DR PLAZA-611 HARRIET ST EVANSVILLE 47710	GS	296	O'BRIEN, RAYMOND, J, 1601 FRANKLIN ST MICHIGAN CITY 46360	ORS	176
NORBERG, CHRISTOPHER, S, 515 NORTH LAFAYETTE SOUTH BEND 46601	OBG	258	O'BRYAN, RICHARD, BRUCE, 2739 CENTRAL AVE COLUMBUS 47201	PD	014
NORDSCHOW, CARLETON, D, 1100 W MICHIGAN ST INDIANAPOLIS 46202	CLP	134	O'DONOVAN, CORNELIUS, J, MILES LABS INC ELKHART 46514	IM	070
NORINS, ARTHUR, LEONARD, 1100 W MICHIGAN INDIANAPOLIS 46202	D	134	O'NEILL, MARTIN, JAMES, 301 WASHINGTON ST VALPARAISO 46383	OS	230
NORMAN, WILLIAM, H, 115 N PENNSYLVANIA ST RM 1252 INDIANAPOLIS 46204	ORS	134	O'ROURKE, CARROLL, 604 W BERRY ST FORT WAYNE 46802	OPH	082

OCA,CLEMENTE,FERNANDEZ, 207 SPARKS AVE JEFFERSONVILLE 47130	CD	034	ONG,TIONG,GIOK, 1005 N CAMPBELL ST VALPARAISO 46383	GP	230
OCHSNER,EDWARD,C, GREENWOOD RADIOLOGY 622 N MADISON AVE GREENWOOD 46142	DR	118	ONORATO,JOS,J, 2433 S 9TH ST LAFAYETTE 47905	IM	286
OCHSNER,HAROLD,CONRAD, 5850 SUNSET LANE INDIANAPOLIS 46260	R	134	ONYETT,HAROLD,R, P O BOX 358 GREENWOOD 46142	GP	134
ODRCIC,KAZIMIR,JURAJ, 211 N EDDY SOUTH BEND 46617	OPH	258	OPPENHEIM,BERNARD,E, 2023 WHITEWOOD COURT INDIANAPOLIS 46260	NM	134
ODULIO,BENITO,V, 121 6TH ST MITCHELL 47446	GS	182	ORNELAS,JOS,PAUL, 6111 HARRISON ST MERRILLVILLE 46410	A	174
ODULIO,BRUNHILDA,IRIS, HWY 60 EAST RFD 2 MITCHELL 47446	IM	182	ORR,W,ROBERT, 12388 EAST JEFFERSON RD MISHAWAKA 46544	ORS	258
GEHLER,NANCY,LEE MARTIN, 725 S FOREST AVE BRAZIL 47834	PM	038	OSBORNE,JOHN,V, 420 W WASHINGTON ST MUNCIE 47305	GS	062
OEHLER,ROBT,CURTIS, 725 SOUTH FOREST AVE BRAZIL 47834	IM	038	OSTER,JACK,H, 1909 BEECH ST VALPARAISO 46383	P	230
OEI,TJEN,OEN, 1100 WEST MICHIGAN ST INDIANAPOLIS 46202	PTH	134	OSTHEIMER,GEO,JAMES, SUNNYSIDE DR BOX 23 MARTINSVILLE 46151	GP	202
OFFUTT,ANDREW,CARROLL, 750 N CAMPBELL AVE INDIANAPOLIS 46219	PH	134	OSWALD,ROBT,HAROLD, 326 S E 7TH ST EVANSVILLE 47713	OBG	296
OGLE,ROBT,WAYNE, 622 NORTH MADISON AVE GREENWOOD 46142	GP	158	OSWALT,JAMES,TELFER, 2900 W 16TH ST BEDFORD 47421		182
OLDAG,GEO,EDWARD, 1402 SOUTH F ELWOOD 46036	GS	186	OVERLEY,TONER,MORTON, 8333 N ILLINOIS ST INDIANAPOLIS IN 46260	P	134
OLSON,DONALD,T, 919 E JEFFERSON BLVD SOUTH BEND 46622	CD	258	OVERPECK,GEO,H, RR 4 BOX 275 ALEXANDRIA 46001	GP	186
OLSON,KENNETH,L, 919 E JEFFERSON BLVD SOUTH BEND 46622	R	258	OWEN,HUGH,THOS, 207 SPARKS AVE JEFFERSONVILLE 47130	D	296
OLSON,L,DALE, VALPARAISO ORTHOPEDIC CLINIC 2501 CUMBERLAND DR VALPARAISO 46383	ORS	230	OWEN,JOHN,ELBA, 11329 ROLLING SPRING DR CARMEL 46032	GS	134
OLVEY,OTTIS,NIEL, 420 W KESSLER BLVD INDIANAPOLIS 46208	IM	134	OWEN,THOS,FREDRIC, 313 N HARRISON ST ALEXANDRIA 46001	GP	186
OMSTEAD,MILTON,HARVEY, 110 S 6TH ST PETERSBURG 47567	GP	226	OWENS,TRACY,CLIFTON, 2211A ROME DR INDIANAPOLIS 46208	P	134
			OWENS,WALTER,LEE, 421 W 1ST ST BLOOMINGTON 47401	OBG	214

WISLEY, GUY, ARGYLE, 214 N HIGH ST HARTFORD CITY 47348	OTO	062	PANCOST, VERNON, K, 1000 W MARION ST ELKHART 46514	GP	070
			PANGAN, ZANITA, S, 802 LA PORTE VALPARAISO 46383	OBG	230
P					
AFF, JAMES, RICHARD, 3308 SUSAN DRIVE KOKOMO 46901	PTH	062	PANOS, CONSTANTINE, GEO, 227 S MAIN ST BLUFFTON 46714	GP	318
AFF, WM, ALFRED, 1509 MEDOW LN ELKHART 46514	IM	070	PANSZI, JOSE, G, 2724 WEST NORTH ST MUNCIE 47304	N	062
AIK, BO, WOOK, 303 S MAIN ST MISHAWAKA 46544	IM	258	PANTZER, JOHN, GEO, 1815 N CAPITOL AVE NG 312 INDIANAPOLIS 46202	PS	134
AIK, GUN, SIL, 1225 COOLSPRING AVE MICHIGAN CITY 46360	OBG	178	PAPADOPOULOS, A, P, 2200 CALIFORNIA ROAD ELKHART 46514	ORS	070
AINE, GEO, ELSNER, 329 MEISNER ST ELKHART 46514	AN	070	PAPPAS, EDDIE, THOS, 6429 ARTHUR ST MERRILLVILLE 46410	GP	174
PAINTER, DONALD, SCOTT, 220 MED CTR BLDG FORT WAYNE 46802	OBG	082	PARAISO, ANTONIO, QUEVEDO, 830 SIM HODGIN PKWY RICHMOND 47374	OBG	314
PAINTER, LOWELL, WALTER, 124 E FRANKLIN ST WINCHESTER 47394	ABS	246	PARAS, JOSE, LINGKOD JUANE, BATESVILLE IN 47006	GP	250
PAIRITZ, FRANK, DAVID, 919 E JEFFERSON BLVD SOUTH BEND 46622	R	258	PARIS, DURWARD, WHITEMAN, 614 ARMSTRONG KOKOMO 46901	IM	126
PALMER, BARRON, M F, 6134 COLUMBIA AVE HAMMOND 46320		174	PARIS, JOHN, MERKILL, 1919 STATE ST STE 321 NEW ALBANY 47150	FP	078
PALMER, HARLEY, PERRY, 1500 N RITTER PATHOLOGY DEPT INDIANAPOLIS 46219	CLP	158	PARK, BYRON, J, 1250 CHESTER BLVD RICHMOND 47374	ORS	314
PALMER, ROBERT, M, 2020 W 86TH ST SUITE 305 INDIANAPOLIS 46260	ORS	134	PARK, HEE, MYUNG, 3102 LEHIGH COURT INDIANAPOLIS 46268	NM	134
PALMER, ROBT, W, 5626 EAST 16TH ST INDIANAPOLIS 46218	IM	134	PARK, JASON, Y S, 7619 MONTICELLO DR TERRE HAUTE 47802	P	298
PAMINTUAN, FLORINO, GANDO, 7905 CALUMET AVE MUNSTER 46321	CD	174	PARKE, WM, COULTER, 2335 DUBOIS DR WARSAW 46580	GP	166
PAN, CHAS, CHIEH-MING, 700 BROADWAY FORT WAYNE 46802	PTH	082	PARKER, E, CAMILLE KILLIAN, 2500 E BROADWAY LOGANSPOET 46947	OPH	030
PANCHOLY, NAVIN, CHIMANLAL, 1025 MANCHESTER WABASH 46992	GS	302	PARKER, FRANCIS, WM, 2500 E BROADWAY LOGANSPOET 46947	OPH	030
PANCNER, RONALD, JERRY, 1812 FORT WAYNE NATL BANK BLDG FORT WAYNE 46802	P	082	PARKER, GEO, FRANCIS, 1502 NORTH EMERSON INDIANAPOLIS 46219	PDA	134

PARKER, JOHN, CARL, BOX 298 GOODLAND 47948	GP	204	PATEL, RASHMI, CHIMANLAL, 7550 HOHMAN AVE MUNSTER 46321	GS	174
PARKER, JOHN, FRANCIS, 5165 E PLEASANT RUN PKWY INDIANAPOLIS 46219	GP	134	PATEL, UPENDRA, H, 7550 HOHMAN AVE MUNSTER 46321	ORS	174
PARKS, GEO, OAKS, 720 N SPRING ST HARTFORD CITY 47348	GP	062	PATHEJA, SURJIT, SINGH, 4001 SLEIGHBELL CT VALPARAISO 46383	OK	230
PARKS, HERBERT, EUGENE, 5533 OVERBROOK CIRCLE INDIANAPOLIS 46219	R	134	PATRON, LEONARDO, A, 306 BINFORD ST CULVER HOSPITAL CRAWFORDSVILLE 47933	AN	198
PARMENTER, HARRY, B, 502 AMERICAN BANK BLDG VINCENNES 47591	AN	162	PATTERSON, JACK, WALTER, 6211 COVINGTON RD FORT WAYNE 46804	GS	082
PARR, ROBT, LOWELL, 5430 E 21ST ST INDIANAPOLIS 46218	PD	134	PATTERSON, WM, K, 8 S PARK DR ANDERSON 46011	AN	186
PARRATT, LOUIS, WARDROP, 504 BROADWAY GARY 46402	GP	174	PATTISON, JOHN, DAVID, 131 N WASHINGTON ST MARION 46952	IM	098
PARRISH, RICHARD, K, 238 S 2D ST DECATUR 46733	DPH	010	PATTON, CHAS, NATHAN, 1001 LIFE BLDG LAFAYETTE 47901	AN	286
PARROT, DONALD, JEROME, 810 W STATE ST FORT WAYNE 46808	GP	082	PAUL, EUELL, GEO, 7550 HOHMAN AVE MUNSTER 46321	GS	174
PARSHALL, DALE, BRYAN, ELKHART GEN HOSP ELKHART 46514	R	070	PAUSZEK, ROBT, BRUCE, 6419 JOHNSON ROAD INDIANAPOLIS 46220	PD	134
PARSONS, ROBT, LA RUE, 919 E JEFFERSON BLVD SOUTH BEND 46622	ORS	258	PAUSZEK, THOS, B, 916 RIVERSIDE DR SOUTH BEND 46616	OBG	258
PASALICH, JOHN, NOVAK, 6211 COVINGTON ROAD FORT WAYNE 46804	R	082	PAVELKA, RONALD, PETER, 7905 CALUMET MUNSTER 46321	ORS	174
PASCUZZI, CHRIS, A, 531 N MAIN ST SOUTH BEND 46601	PTH	258	PAVLICK, THEODORE, JOS, 1001 WALNUT ST EVANSVILLE 47713	OPH	296
PASILABBAN-BANGUIS, L, M, 103 W WASHINGTON ST SHELBYVILLE 46176	IM	266	PAYNE, ARTHUR, C, 2020 BROADWAY EAST CHICAGO 46312	GP	174
PASTOR, JULIUS, WM, 5901 WASHINGTON AVE EVANSVILLE 47715	AN	296	PAYNTER, MORRIS, BURTON, 115 WHITE HORSE LIV NOBLESVILLE 46060	GP	134
PATEL, MANUBHAI, P, COUNTRY CLUB HILLS R R 3 KENDALLVILLE 46755	GS	206	PAYNTER, WM, T, 1330 W MICHIGAN ST INDIANAPOLIS 46206	P	134
PATEL, PULKIT, JOITARAM, 7003 WILLIAMSBURG LN TERRE HAUTE 47802	U	298	PAZ, LUIS, AUGUSTO, 1007 N 16TH ST NEW CASTLE 47362	U	122
PATEL, RAMESHCHANDRA, I, KEM VIEW MEDICAL CENTER 1251 KEM ROAD MARION 46952	PD	098	PEACOCK, NORMAN, F, 219 BEN HUR BLDG CRAWFORDSVILLE 47933	OTO	198

PEACOCK,ROBT,COWDEN, 2724 W NORTH ST MUNCIE 47303	U	062	PELL,DONALD,MC LAURY, 3729 WEST JACKSON ST MUNCIE 47304	IM	062
PEARCE,ROBT,MICHAEL, 5430 EAST 21ST ST INDIANAPOLIS 46218	P	134	PEMBERTON,JACK,JAMES, 611 HARRIET EVANSVILLE 47710	GP	296
PEARCE,ROY,VOYLES, 1440 S 25TH ST TERRE HAUTE 47803	GP	298	PENKAVA,ROBT,RAY, 611 HARRIET ST EVANSVILLE 47715	DR	296
PEARCY,MARCENE, P O BOX 987 MARION 46952	U	096	PENN,ROBT,ALLAN, 3820 CENTRAL AVE EAST GARY 46405	GP	174
PEARE,REEVE,BURTON, MEDICAL ARTS BLDG 1255 ENGLE ST HUNTINGTON 46750	GP	130	PERALTA,JOSE, 411 TINSLEY AVE CRAWFORDSVILLE 47933	GS	198
PEARSON,HUEY,LAWRENCE, 2314 S HANNA ST FORT WAYNE 46803	GP	082	PERCINEL,AHMET,KEMAL, 801 ST MARYS DR EVANSVILLE 47715	HS	296
PEARSON,JACK,WILLARD, 11715 EDEN GLEN DR CARMEL 46032	DBG	134	PEREZ,CESAR,EDELBERTO, P O BOX 622 CARMEL 46032	AN	134
PEARSON,JOHN,STROTHER, ONE WEST 26TH ST INDIANAPOLIS 46206	DM	134	PERKINS,POWELL,LEON, 317 S BERKLEY ST KOKOMO 46901	GS	126
PEARSON,LYMAN,REES, 632 EDGEWATER DR 431 DUNEDIN FL 33528	CRS	134	PERRIN,KERMIT,FLOYD, 2701 S ANTHONY BLVD FORT WAYNE 46806	GP	082
PEARSON,WM,EPHRIUM, 290 N WABASH ST WABASH 46992	GP	302	PERRIN,NELLJEAN, 10412 HOLIDAY DRIVE CARMEL 46032	PD	134
PECK,FRANKLIN,B, 8181 LINCOLN BLVD INDIANAPOLIS 46240	IM	134	PERRY,GUY,FELAND, 605 COTTAGE COHA COLUMBUS 47201	DM	014
PECK,FRANKLIN,BRUCE, 5858 W LAZY S TUCSON AZ 85713	IM	134	PERSON,THEODORE,C, 601 N MILL ST VEEDERSBURG 47987	GP	086
PECK,JAMES,FRANK, 302 N PRINCE ST PRINCETON IN 47670	GP	094	PESARILLO,SERVANDO,N, 401 E REYNOLDS KOKOMO 46901	GP	126
PEDDICORD,CLIFFORD,R, R R 3 RENSSELAER 47978	DR	030	PESIGAN,CONRADO,SISON, 116 SOUTH DELPHIA PARK RIDGE IL 60068	R	174
PEDEN,EMMA,JANE, 1303 N ARLINGTON INDIANAPOLIS 46219	IM	134	PETERS,ELMER,E, 830 MAIN ST BROOKVILLE 47012	GP	074
PEDEK,MARIA,A, EVANSVILLE STATE HOSP EVANSVILLE 47715	GP	296	PETERSON,DEWARD,D, 221 S 6TH ST TERRE HAUTE 47801	R	296
PEIFFER,GERALDINE,M, ST MARGARET HOSP HAMMOND 46320	AN	174	PETERSON,JAMES,ARTHUR, ELKHART CLINIC BOX 2507 ELKHART 46514	PD	070
PEIRCE,JAMES,D, 5027 WASHINGTON BLVD INDIANAPOLIS 46205	DM	134	PETERSON,RONALD,L, 116 E WASHINGTON ST PLYMOUTH 46563	FP	190

PETITJEAN, HAROLD, GEO, R D 2 HAUBSTADT IN 47639	FP	094	PHILLIPS, JOHN, HARMON, 1511 WABASH ST MICHIGAN CITY 46360	GP	178
PETRANOFF, THEODORE, V, 2814 QUESTEND S DR INDIANAPOLIS 46222	GP	134	PHIPPS, LELAND, K, R R 1 BOX 73 UNION CITY 47390	GP	246
PETRASS, ANDREW, 22027 LIBERTY HWY SOUTH BEND 46601	GP	258	PHITHAYANUKARN, JOSEFINA, P O BOX 102 WESTVILLE 46391		174
PETRICH, PETER, RICHARD, 401 S PERRY ST ATTICA 47918	GP	086	PICKETT, MERLE, ELMER, 5800 FAIRFIELD AVE FORT WAYNE 46807	AN	082
PETRIN, THOS, JOHN, 7005 GROSVENOR PLACE INDIANAPOLIS 46208	IM	134	PICKETT, ROBT, D, 3524 N MERIDIAN ST INDIANAPOLIS 46208	IM	134
PETRY, THOS, NEAL, 110 S UNION ST DELPHI 46923	GP	026	PIERCE, EMMETT, C, BOX 706 GREENFIELD 46140	PTH	134
PETTIS, AKTHUR, GLASCO, METHODIST HOSP GARY 46402	AN	174	PIERCE, GENE, STRATTON, 112 PROF ARTS BLDG-1919 STATE NEW ALBANY 47150	FP	078
PEYTON, FRANK, WOOD, 2400 FERRY ST LAFAYETTE 47904	OBG	286	PIERCE, WM, J, DIAGNOSTIC CYTO CLINIC BRUCEVILLE 47516	PTH	046
PFAFF, DUDLEY, A, 25 EAST 40TH ST APT 5-D INDIANAPOLIS 46205	GYN	134	PIETZ, DAVID, GEO, 303 S MAIN ST BLUFFTON 46714	GE	318
PFEIFER, JAMES, MORRIS, 319 FRONT ST LAWRENCEBURG 47025	IM	050	PILE, STAFFORD, WALLACE, 8109 BRAMWOOD COURT INDIANAPOLIS 46250	U	134
PFROMMER, JOHN, R, 2600 GREENBUSH ST LAFAYETTE 47904	AM	286	PILECKI, PETER, J, 1225 E COOLSPRING AVE MICHIGAN CITY 46360	GP	178
PFUETZE, MAX, ENSIGN, 408 NORTH ST LOGANSPOUT 46947	OM	030	PILLAI, VIJAYAN, V, DUNN MEMORIAL HOSP BEDFORD 47421	GS	182
PHARES, ROBT, WESLEY, 1712 S MALFALFA RD KOKOMO 46901	AN	126	PILLAY, VIJAYAPRASANTHAN, 1000 EAST 80TH ST SUITE 525 MERRILLVILLE 46410	NS	174
PHELPS, JAMES, MICHAEL, 4425 N 250 W WEST LAFAYETTE 47906	R	286	PILOT, JEAN, 7137 KNICKERBOCKER HAMMOND 46323	PTH	174
PHELPS, STEPHEN, ROWLES, 808 SHERLAND BLDG SOUTH BEND 46601	D	258	PIPPENGER, JOS, IRWIN, 310 W JACKSON ST MUNCIE 47305	GP	062
PHILBROOK, SETH, S, 705 HARRISON ST LA PORTE 46350	OPH	178	PIPPENGER, WAYNE, GRISE, 1 WESTWOOD DR FRANKFORT 46041	GP	042
PHILLIPS, DAVID, LEE, 3561 N PENNSYLVANIA INDIANAPOLIS 46205	P	134	PITTMAN, JOHN, NORMAN, 201 W 106TH ST INDIANAPOLIS 46290	CDS	134
PHILLIPS, DONALD, MICHAEL, 1356 S LAKE PARK HOBART 46342	GP	174	PITTS, NEAL, CHASE, 303 S MAIN ST BLUFFTON 46714	RHU	318

IZZO, ANTHONY, BLOOMINGTON HOSP BLOOMINGTON 47401	PTH	214	POOLITSAN, GEO, CHRIS, 907 W 2ND ST BLOOMINGTON 47401	IM	214
LAIN, GEO, SOUTH BEND CLINIC-211 N EDDY SOUTH BEND 46617	GS	258	POPE, HOWARD, A, 1919 STATE ST SUTE 205 NEW ALBANY 47150	FP	078
LAIN, GEO, L, 1229 RIDGEDALE SOUTH BEND 46614	IM	258	POPE, WARREN, DEAN, BOX 46 R R NO 1 CONNERSVILLE 47331	OM	074
MASTERER, EDWARD, DALE, 1434 CHESTER BLVD RICHMOND 47374	PD	314	POPLAWSKI, HENRY, 202 MARQUETTE MALL BLDG MICHIGAN CITY 46360	GP	178
LATIS, JAMES, MARK, 1000 E 80TH PL MERRILLVILLE 46410	PS	174	POPP, MILTON, FREDERICK, 3148 PARNELL AVE FORT WAYNE 46805	EM	082
LESS, JOHN, EDWARD, 3516 BRADLEY BLOOMINGTON 47401	PTH	182	POPPELWELL, ARVINE, G, 6555 GLACIER DR INDIANAPOLIS 46217	PUD	134
LETCHER, WM, DE WITT, ELKHART CLINIC BOX 2507 ELKHART 46514	IM	070	PORACKY, BERNARD, F, 148 SHORE DR BOX 639 OGDEN DUNES PORTAGE 46368	R	230
LOETNER, EDWARD, JOS, MED ARTS BLDG 721 W 13TH ST JASPER 47546	GS	066	PORRO, FRANCIS, WALTHOUR, 3700 WASHINGTON AVE EVANSVILLE 47715	PTH	296
DEHLER, FREDERICK, CHAS, 6 E KENDALL LA FONTAINE 46940	AN	302	PORTER, GEO, SETH, 900 SIM HODGIN PKWY RICHMOND 47374	OBG	314
OHNERT, WILLIAM, H, 402 BERKLEY KOKOMO 46901	ORS	126	PORTER, JOHN, R, 1122 N LEBANON LEBANON 46052	GP	022
DLCZ, GYORGY, GYULA, 4604 CARDINAL DR MUNCIE 47304	OS	062	PORTER, ROBT, A, 328 EAST FRANKLIN ST WINCHESTER 47394	GP	246
OLHEMUS, WARREN, C, 1803 PEARL ST ANDERSON 46016	GP	186	PORTNEY, FRED, R, 7905 CALUMET AVE MUNSTER 46321	U	174
OLITE, NICHOLAS, LOUIS, 837 119TH ST WHITING 46394	OBG	174	POTTER, BRIAN, S, 1225 E COOLSPRING MICHIGAN CITY 46360	D	178
OLLACK, SEYMOUR, LESTER, 511 EDGEWOOD DR NEW CASTLE 47362	N	122	POTTI, T, K KRISHNAN, 1000 EAST 80TH PLACE MERRILLVILLE 46410	IM	174
OMPUTIUS, WM, FRANCIS, GOOD SAMARITAN HOSP 520 SOUTH 7TH ST VINCENNES 47591	PTH	162	POTTS, DAVID, R, 2600 GREENBUSH ST LAFAYETTE 47904	OBG	286
ONCHER, JOHN, ROBERT, 1101 E GLENDALE BLVD VALPARAISO 46383	PD	230	POULOS, JAMES, THOS, 2600 GREENBUSH ST LAFAYETTE 47904	END	286
ONTAODE, ALEJANDRO, GARCIA, 613 WEINBACH AVE EVANSVILLE 47714	P	296	POULOS, WARD, ELIAS, 3500 LAFAYETTE RD INDIANAPOLIS 46222	PD	134
ONTIUS, EDWIN, EUGENE, METHODIST HOSP INDIANAPOLIS 46202	PTH	134	POWELL, JAMES, PAXTON, 500 WABASH AVE MARION 46952	GS	098

POWELL,MELVIN,JACK, 700 BROADWAY FORT WAYNE 46804	K	082	PRIMUS,ROMANA,R, 211 N EDDY ST SOUTH BEND 46617	PD	25
POWELL,RICHARD,CINCLAIR, 5359 HEDGEROW DR INDIANAPOLIS 46226	END	134	PROBST,EDWARD,LOUIS, TIPTON PARK PLAZA 360-C PLAZA DRIVE COLUMBUS 47201	D	01
POWERS,PAUL,CHAS, 110 NORTH CHERRY MUNCIE 47305	GS	062	PROUDFIT,CHAS,H, 919 E JEFFERSON ST SOUTH BEND 46622	GYN	25
POWERS,WM,RAY, LYONS CLINIC LYONS 47443	FP	102	PROVINCE,WM,DITMARS, 100 N MAIN ST FRANKLIN 46131	IM	15
PRATHER,PHILIP,E, 123 MAGNOLIA KOKOMO 46901	FP	126	PRUITT,DON,E, RR 8 BOX 144 EVANSVILLE 47711	R	09
PRATT,GEORGE,B, 320 RAINTREE DR ZIONSVILLE 46077	R	134	PRUITT,JACOB,E, 540 TYLER ST GARY 46402	GP	17
PRATT,RALPH,MARTIN, 2325 BLACKMORE PL MADISON 47250	PTH	150	PRYOR,RICHARD,C, 6111 N COLLEGE AVE INDIANAPOLIS 46220	GP	13
PREDG,ADOLPH,C, 909 MADISON ST LA PORTE 46350	GP	178	PUGH,WM,ROBT, 115 S LINCOLN BLOOMINGTON 47401	OTO	21
PREDG,FLORIAN,MARTIN, 1225 E COOLSPRING AVE MICHIGAN CITY 46360	GS	178	PULCINI,JOHN,UENNIS, 3700 BELLEMEADE AVE STE 203 EVANSVILLE 47715	PS	29
PREMUDA,FRANKLIN,FRED, 7042 WOODMAK AVE HAMMOND 46323	EM	174	PULLMAN,GEO,R, 1031 COUNTRY CLUB LANE WARSAW 46580	R	16
PRESENT,JULIAN,D, 3700 BELLEMEADE AVE EVANSVILLE 47715	GP	296	PULSKAMP,BERTRAND,H, BOX 55 WOLCUTTVILLE 46795	GP	20
PRIBBLE,ROBT,HOWARD, 5717 ROXBURY CIR INDIANAPOLIS 46226	PTH	134	PURCELL,LAWRENCE,T, 303 S MAIN ST BLUFFTON 46714	U	31
PRICE,AMBROSE,MADISON, 1431 N MADISON AVE ANDERSON 46012	GP	186	PURCELL,RICHARD,J, 443 GLENWOOD DR GRIFFITH 46319	FP	17
PRICE,FRANCIS,W, 745 FOREST BLVD ZIONSVILLE 46077	OM	134	PUTERBAUGH,KARL,E, 104 W STATE ST ALBANY 47320	GP	06
PRICE,JAMES,OWEN, 6433 PARK CENTRAL DR W INDIANAPOLIS 46260	GS	134	PYLE,HAROLD,D, 14432 ARROWHEAD COURT SUN CITY AZ 85351	PD	25
PRICE,ROBT,WHITCRAFT, 2600 OAKLAND AVE ELKHART 46514	P	070	PYLE,SUSAN,K, 1150 N COLUMBIA ST UNION CITY 47390	GP	24
PRICE,SHIRLEY,G, 421 CHESTNUT ST EVANSVILLE 47713	GS	296			
PRIDDY,MARVIN,EUGENE, 5110 N CLINTON FORT WAYNE 46825	GP	082	QAZI,HAROON,MOHAMMAD, 1944 NORTH CAPITOL AVE INDIANAPOLIS 46202	PS	13

QUAKENBUSH, JOHN, PHILLIP, 3421 S LA FOUNTAINE KOKOMO 46901	GP	126	RAHMANY, MOHAMMAD, ASEF, 4321 FIR ST EAST CHICAGO 46312	GP	174
QUICK, WM, JOS, R R 11 BOX 195 MOORE ROAD MUNCIE 47302	GP	062	RAI, SWAROOP, MEDICAL ARTS PLAZA P O BOX 269 HUNTINGBURG 47542	CD	066
QUIGLEY, GEO, JOS, 5506 EAST 16TH ST SUITE 17 INDIANAPOLIS 46218	UPH	134	RAJU, GOPAL, S, FAIRMOUNT CLINIC FAIRMOUNT 46928	GS	098
QUIGLEY, JOS, WM, 6320 NORTH FERGUSON INDIANAPOLIS 46220	GP	134	RAK, RICHARD, ALAN, 619 WEST FIRST ST BLOOMINGTON 47401	NS	214
QUILTY, THOS, JAMES, 112 E MADISON ST GOSHEN 46526	OTO	070	RALSTON, MARC, ALLEN, 2600 GREENBUSH ST LAFAYETTE 47904	GPH	286
QUINN, MICHAEL, GERALD, 531 N MAIN ST SOUTH BEND 46601	PTH	258	RAMAGE, WALTER, FRANCIS, 5440 SHELBYVILLE RD INDIANAPOLIS 46227	GP	134
			RAMAPRAKASH, H, N, 2828 FAIRFIELD AVE FORT WAYNE 46807	OBG	082
R RABASA, RAFAEL, 303 S MAIN ST SUITE 103 MISHAWAKA 46544	GP	258	RAMKER, DANL, THEODORE, 7040 KENNEDY ST HAMMOND 46323	GS	174
RABB, HARRY, SOLOMON, ROUTE 1 BOX 181D NINEVEH 46164	OS	134	RAMOS, LEONARDO, POSADAS, BURDEN 47106	GP	034
RABELO, JOHN, SEGUNDO, BOX 96 BEVERLY SHORES 46301	AN	230	RAMSDELL, GLEN, AUSTIN, 1200 CHESTER BLVD RICHMOND 47374	PUD	314
RABER, ROBT, M, 3266 NORTH MERIDIAN ST NO 605 INDIANAPOLIS 46208	PS	134	RAMSEY, FRANK, BANTA, 1401 WEST 52ND ST INDIANAPOLIS 46208	GS	134
RABIN, RONALD, PHILIP, 611 HARRIET ST SUITE NO 504 EVANSVILLE 47710	U	296	RAMSEY, GEO, FRANK, 2600 GREENBUSH ST LAFAYETTE 47902	IM	286
RADCLIFF, FORREST, F, 801 ST MARYS DR EVANSVILLE 47715	ORS	296	RAMSEY, HUGH, SMITH, 619 E FIRST ST BLOOMINGTON 47401	GP	214
RADCLIFFE, LEE, EWING, 2464 SYCAMORE LN WEST LAFAYETTE 47906	P	286	RAMSEY, JOHN, EDWARD, U S HIGHWAY 6 WEST P O BOX 707 KENDALLVILLE 46755	GP	206
RADPOUR, SHOKRI, 315 S BERKLEY RD KOKOMO 46901	OTO	126	RAMSEY, PAUL, L, 1431 N MADISON AVE ANDERSON 46012	ORS	186
RAGAN, WM, D, 11416 LAKESHORE DRIVE E CARMEL 46032	OBG	134	RANCK, BENJ, ALBERT, 2600 SANDCREST BLVD COLUMBUS 47201	GP	014
RAHUERT, RICHARD, F, 2600 GREENBUSH ST LAFAYETTE 47904	CHP	286	RANDOLPH, JOSEPH, C, 2900 GALAHAD DR INDIANAPOLIS 46208	ORS	134
RAHMAN, SHEIKH, ABDUL, 605 WILSON CREEK RD LAWRENCEBURG 47025		050	RANEY, BEN, BUTLER, 129 E VINCENNES ST LINTON 47441	AN	102

RANEY, ROBT, DONALD, 1024 S 6TH ST TERRE HAUTE 47802	IM	298	RAYMUNDU, LUCIANO, CABATE, 800 MACARTHUR BLVD MUNSTER 46321	OKS	174
RANG, ROBT, HALTER, 300 NE 14TH WASHINGTON 47501	GS	046	RAYMUNDO, VIVENCIO, F, 1336 SOUTH B STREET ELWOOD 46036	GS	186
RANK, WM, BENJ, 3030 LAKE FORT WAYNE 46805	U	082	REA, RALPH, LEWIS, 120 W MC KENZIE RD GREENFIELD 46140	FP	110
RAD, CHALAPATHI, C, 1100 W MICHIGAN INDIANAPOLIS 46202	AN	134	READ, JOHN, E, 229 EAST MORGAN AVE CHESTERTON 46304	OPH	230
RAPP, GEORGE, F, 8402 HARCOURT RD INDIANAPOLIS 46260	ORS	134	RECEVEUR, PAUL, E, 2626 CHARLESTON RD NEW ALBANY 47150	GP	078
RASCH, GEO, C, 1644-45TH AVE SUITE C MUNSTER 46321	GS	174	RECEVEUR, ROBT, LEWIS, 2626 CHARLESTOWN RD NEW ALBANY 47150	GP	078
RASMUSSEN, RUTH, FRANCES, 211 N EDDY ST SOUTH BEND 46617	PTH	258	RECORDS, JOHN, MERRITT, 198 E JEFFERSON ST FRANKLIN 46131	FP	158
RATCLIFF, FRANK, WM, 1000 WEA AVE LAFAYETTE 47905	AN	286	REDDY, RAMACHANDRA, K, 1100 W MICHIGAN ST INDIANAPOLIS 46202	DR	134
RATCLIFFE, A, WAYNE, BOX 138 EVANSVILLE 47715	PTH	296	REECK, CLAUDE, C, 8291 WASHINGTON BLVD INDIANAPOLIS 46260	ORS	134
RAU, CHAS, ALBERT, 2600 SANDCREST BLVD COLUMBUS 47201	FP	014	REED, DONALD, WAITE, 1305 SHERWOOD DR GREENFIELD 46140	P	110
RAUH, ROBT, A, 884 NORTH MIAMI ST WABASH 46992	GP	302	REED, EDESEL, SHERWOOD, 1220 MISSOURI AVE JEFFERSONVILLE 47130	R	034
RAUSCH, NORMAN, W, 416 E MAUMEE ST ANGOLA 46703	GP	278	REED, JAMES, CHILTON, ELKHART CLINIC P O BOX 2507 ELKHART 46514	D	070
RAWLINS, CAROLYN, N MANN, 7550 HOHMAN AVE MUNSTER 46321	OBG	174	REED, JAY, ALLEN, 110 LAKEVIEW DRIVE NOBLESVILLE 46060	GP	106
RAWLINS, STEVEN, JOE, 6111 HARRISON ST MERRILLVILLE 46410	R	174	REED, JOHN, DAVID, 3124 E STATE BLVD FORT WAYNE 46805	IM	082
RAWLS, GEO, HOSEA, 3151 N ILLINOIS ST INDIANAPOLIS 46208	GS	134	REED, JOHN, JOS, 10 N MICHIGAN AVE HOBART 46342	FP	174
RAY, CARL, STEWART, % RCA M O BOX 1976 INDIANAPOLIS 46206	OM	134	REED, PHILIP, BYRON, BOX 14132 ST PETERSBURG FL 33707	P	134
RAY, JAMES, ANTHONY, 321 W 2ND ST BLOOMINGTON 47401	GP	214	REED, ROBT, CECIL, UNION HOSPITAL TERRE HAUTE 47808	AN	298
RAYES, JOS, LUKE HASSAN, 1814 SHERMAN DR PRINCETON 47670	GS	094	REED, ROBT, F, 1316 LINCOLN WAY E MISHAWAKA 46544	GP	258

REED,ROBT,G, 2400 E 17TH ST COLUMBUS 47201	PTH	014	RENDEL,DONALD,T, 513 RIDGE RD MUNSTER 46321	PD	174
REED,ROBT,G, 1303 N ARLINGTON AVE INDIANAPOLIS 46219	CD	134	RENDEL,HAROLD,EUGENE, 302 N DUKE ST PERU 46970	GP	194
REED,ROGER,ROLLIN, 1415 RAIBLE AVE ANDERSON 46011	GRS	186	RENDEL,JEFFRY,CHAS, JASPER MEDICAL ARTS BLDG JASPER 47546	EM	066
REED,RONALD,RILEY, 2450 169TH ST HAMMOND 46323	IM	174	RENNE,JAMES,WILLIAM, 421 CHESTNUT ST EVANSVILLE 47713	GRS	296
REED,THOS,EVAN, 120 W MARKET STREET INDIANAPOLIS 46204	GP	134	REPAY,WALTER,ALLEN, 513 RIDGE RD MUNSTER 46321	GP	174
REEDY,RICHARD,LEE, 1003 E SMITH ST YORKTOWN 47396	GP	062	REPPERT,ROLAND,LE ROY, ROAD 224 DECATUR 46733	GP	010
REEDY,STANLEY,GENE, 423 PROSPECT ELKHART 46514	PH	070	RESS,GENE,EDWIN, PROFESSIONAL BLDG TELL CITY 47586	GP	222
REES,RUSSEL,C, 6114 E WASHINGTON ST INDIANAPOLIS 46219	GP	134	RESZEL,PAUL,A, 5050 N CLINTON ST FORT WAYNE 46825	GRS	082
REICH,CLARENCE,E, 1209 N FULTON AVE EVANSVILLE 47710	GP	296	REUL,GEO,MARVIN, 6401 WINDWOOD DR KOKOMO 46901	GP	126
REID,CHAS,ALBERT, 2445 SHELBY ST INDIANAPOLIS 46203	GP	134	REUTER,JOHN,WESLEY, R R NO 18 BROOK KNOLL BEDFORD 47421	OPH	182
REID,DONALD,BRAIDWOOD, 2 HALLMARK SQUARE COLUMBIA CITY 46725	GP	326	REYES,ANGEL,I, 1450 E 55TH PL APT 918 SOUTH CHICAGO IL 60637	EM	174
REID,JAMES,DONALD, 932 GUSTAVE PL MARION 46952	OPH	098	REYES,DIEGO,CASTOR, 29 EAST MAIN ST PERU 46970	GP	194
REID,ROBT,WM, 726 W DIVISION ST UNION CITY 47390	OS	246	REYNOLDS,JOHN,L, 1630 SOUTH OHIO STREET MARTINSVILLE 46151	GRS	202
REIMERS,ROGER,ALLEN, P O BOX 1149 BLOOMINGTON 47401	R	214	REYNOLDS,RALPH,EDWARD, RR 1 BOX 53 APT 203 DALEVILLE 47334	AN	186
REINEKE,JAN,RICHARD, 912 E LA SALLE SOUTH BEND 46617	OBG	258	REYNGLOS,RICHARD,J, 650 IDAHO ST TERRE HAUTE IN 47802	IM	298
REITMAN,PAUL,HENRY, 4321 FIR ST EAST CHICAGO 46312	R	174	REZVAN,NADER, 619 W 1ST ST BLOOMINGTON 47401	AN	214
REMICH,ANTONE,CHAS, 7905 CALUMET AVE MUNSTER 46321	OM	174	RHAMY,ARTHUR,P, RR 5 WABASH 46992	U	098
REMO,JOHN,WM, DMI INC P O BOX 1521 LAFAYETTE 47906	DR	286	RHAMY,DONALD,EUGENE, P O BOX 987 MARION 46952	U	098

RHEE, SANG, KEE, 2827 RUSCOMMON FORT WAYNE 46805	AN	082	RICHEY, ROBT, WM, 803 N PARKRIDGE ROAD BLOOMINGTON 47401	OEG	214
RHEINHEIMER, FLOYD, L, BOX 128 MILFORD 46542	FP	070	RICHMOND, HAROLD, WAYNE, CUMMINS ENGINE CO COLUMBUS 47201	OM	014
RHIND, ALEXANDER, WM, 7126 FORREST AVE HAMMOND 46324	GP	174	RICHTER, ARTHUR, B, 8872 WESTFIELD BLVD INDIANAPOLIS 46240	CL	134
RHOADS, PAUL, SPOTTSWOOD, 100 N 15TH ST RICHMOND 47374	IM	314	RICHTER, JOHN, CARL, 900 I ST LA PORTE 46350	GS	178
RHODES, ALFRED, KEITH, 370 BIELBY RD LAWRENCEBURG 47025	OEG	050	RIDER, PAUL, STEVEN, 1434 CHESTER BLVD RICHMOND 47374	PD	314
RHORER, JOHN, GILBERT, 106 PROF ARTS CENTER MARION 46952	FP	098	RIDGE, FREDERICK, RAY, 1100 W MICHIGAN INDIANAPOLIS 46202	FP	134
RHYNEARSON, HAL, ROBT, 110 W STAAT ST FORTVILLE 46040	GP	110	RIDGWAY, ALTON, H, 631 MAIN ST LAPEL 46051	FP	186
RICE, KATHEKINE, KEMPNER, 919 EAST JEFFERSON BLVD SOUTH BEND 46622	P	258	RIEGER, IRWIN, TAYLOR, 711 W 2ND ST BLOOMINGTON 47401	U	214
RICE, RAYMOND, DALTON, 2020 W 86TH ST INDIANAPOLIS 46260	OEG	134	RIEHL, RICHARD, EMIL, 201 E MARKET ST JEFFERSONVILLE 47130	IM	034
RICE, RAYMOND, M, 8465 QUAIL HOLLOW RD INDIANAPOLIS 46260	OS	134	RIESER, ALOYS, MARTIN, ST ANTHONY MED CENTER CROWN POINT 46307	CLP	174
RICH, NORVAL, S, 230 S 2ND ST DECATUR 46733		010	RIETMAN, H, JEROME, 715 1ST AVE EVANSVILLE 47710	P	296
RICH, RICHARD, BUDGE, 1810 E 62ND ST INDIANAPOLIS 46220	OPH	134	RIFNER, EUGENE, SYMONS, 301 E VINE ST VAN BUREN 46991	GP	098
RICHARD, NORMAN, FREDRIC, RR5 BOX 828 LAKE JAMES ANGOLA 46703	ABS	278	RIGG, JOHN, FLOYD, 131 GULFSTREAM RD NORTH PALM BEACH FL 33403	PH	134
RICHARDS, DEAN, ALLEN, 3123 S MICHIGAN ST SOUTH BEND 46614	GP	258	RIGGS, FLOYD, C, 137 S 24TH ST TERRE HAUTE 47803	GP	298
RICHARDS, EDGAR, ELVIN, P O BOX 182 RUSSELLVILLE 46175	GP	198	RIGGS, WENDELL, A, 2600 GREENBUSH ST LAFAYETTE 47902	PD	286
RICHARDSON, JOS, DOWNS, 121 W 8TH ST ROCHESTER 46975	FP	090	RILEY, HENRY, SCHIRMER, 722 W MAIN ST MADISON 47250	GP	150
RICHARDSON, JOS, HILL, 3010 E STATE BLVD FORT WAYNE 46805	IM	082	RILEY, THOS, WAYNE, 3530 S KEYSTONE INDIANAPOLIS 46227	U	134
RICHART, JAMES, VERNON, 336 HAMILTON DR TERRE HAUTE 47803	GP	298	RIMEL, JAMES, FLOYD, 1223 N CENTER ST PLYMOUTH 46563	GS	190

RINER, JACK, KEITH, 5740 RIDGE RD INDIANAPOLIS 46226	GS	134	ROBERTO, BENJ, V, 378 W MAIN ST AUSTIN 47102	GP	262
RINGER, WM, ALFRED, 23 FALL ST WILLIAMSPORT 47993	GP	086	ROBERTS, BILLY, JOE, 3123 MISHAWAKA AVE SOUTH BEND 46615	GP	258
RINK, LAWRENCE, DONALD, 419 WEST FIRST STREET BLOOMINGTON 47401	IM	214	ROBERTS, WARREN, CHAS, 2525 SHADELAND INDIANAPOLIS 46219	OM	134
RIORDAN, JOHN, F, 120 FAIRVIEW AVE VALPARAISO 46383	AN	236	ROBERTSON, ADDIS, NEAT, 1431 SLATE RUN RD-NO 39 NEW ALBANY 47150	GP	078
RIPLEY, JOHN, WM, 321 BRUCE ST SEYMOUR 47274	GP	138	ROBERTSON, JAMES, A, 7209 E WALNUT EVANSVILLE 47715	PTH	296
RIPPERGER, STEVEN, GREG, 421 CHESTNUT EVANSVILLE 47713	OBG	296	ROBERTSON, JAMES, STEWART, 304 N WALNUT ST PLYMOUTH 46563	GP	190
RISSING, WALTER, JOS, 229 W BERRY ST FORT WAYNE 46802	CRS	682	ROBERTSON, ROBT, E, 110 S NEW ALBANY ST SELLERSBURG 47172	GP	034
RITCHEY, JAMES, OSCAR, 43 W 43RD ST INDIANAPOLIS 46208	IM	134	ROBERTSON, WM, CARL, 5 OAK DR DUNE ACRES CHESTERTON 46304	AN	236
RITCHIE, WM, DUDLEY, 567 ULMSTEAD EVANSVILLE 47711	FP	296	ROBERTSON, WM, SIMON, 213 W MAIN ST SPICELAND 47385	OS	122
RITTER, MERRILL, A, 1815 N CAPITOL AVE INDIANAPOLIS 46202	ORS	134	ROBINSON, EARLE, URIAH, 3351 N MERIDIAN STE 200 INDIANAPOLIS 46208	OBG	134
RITTER, WAYNE, LOCKWOOD, 1556B CONSOLIDATED BLDG INDIANAPOLIS 46204	IM	134	ROBINSON, FREDERICK, CHAS, 2600 GREENBUSH ST LAFAYETTE 47904	N	286
RITTMAYER, JOHN, LOUIS, 1309 RIDGE RD MUNCIE 47304	IM	062	ROBINSON, NAN, ELIZABETH, 1726 STATE NEW ALBANY 47150	PD	078
RITZ, ALBERT, SYLVESTER, 3700 BELLEMEADE EVANSVILLE 47715	GS	296	ROBINSON, ROBT, DAWSON, ST VINCENT HOSP 2001 W 86TH ST INDIANAPOLIS 46260	CD	134
RIVERA, FELICIDAD, BALIDO, P O BOX 731 MICHIGAN CITY IN 46360	AN	178	ROBISON, ROGER, FRANK, 902 WEST FIRST ST BLOOMINGTON 47401	ND	214
RIVERA, HECTOR, P, 8911 SPICEWOOD COURT INDIANAPOLIS 46260	PTH	134	ROBY, ALMA, LEE, 207 SPARKS AVE JEFFERSONVILLE 47130	PD	034
RIVERA, JULIUS, PEREGRINO, 3714 FRANKLIN MICHIGAN CITY 46360	GS	178	ROCH, L, MARSHALL, 308 WHITE RIVER BLVD MUNCIE 47303	OPH	662
ROACH, EUGENE, GAYLE, 3705 E KESSLER BLVD INDIANAPOLIS 46220	P	134	ROCHLIN, ISIDORE, 212 EAST 71ST ST INDIANAPOLIS 46220	IM	134
ROBB, JOHN, ALTON, 5151 N PENNSYLVANIA INDIANAPOLIS 46205	R	134	ROCKEY, NOAH, ADAM, 2539 N E 26TH TERR FORT LAUDERDALE FL 33305	OS	082

RODWAY, JOHN, SPENCER, 605 COTTAGE AVE COLUMBUS 47201	GP	014	ROMBERGER, FLOYD, T, 10 WEST 64TH ST INDIANAPOLIS 46260	OBG	134
ROE, TAFI, WM, 3700 BELLEMEADE NO 101 EVANSVILLE 47715	OTO	296	ROMMEL, CLARENCE, HENRY, 456 NORTHWESTERN AVE WEST LAFAYETTE 47906	GS	286
ROEGNER, DONALD, LEE, 3807 B SOUTHLAND AVE KOKOMO 46901	CHP	126	ROOF, ROGER, SAML, 209 E SEMINARY ST GREENCASTLE 46135	GP	242
ROESCH, RYLAND, PAUL, 5439 SHOREWOOD DR INDIANAPOLIS 46220	AN	134	ROOSE, LISLE, WADE, 357 N NAPPANEE ST NAPPANEE 46550	GP	070
ROESKE, NANCY, C ARNOLD, 6815 N PENNSYLVANIA INDIANAPOLIS 46220	CHP	134	ROPP, HAROLD, EDWARD, NEW HARMONY 47631	GP	234
ROGERS, EVERED, EARL, 212 W 6TH ST AUBURN 46706	GP	058	ROS, GEORGE, A, 827 S UNION ST WARSAW 46580	GS	166
ROGERS, ROBERT, E, 1100 W MICHIGAN INDIANAPOLIS 46202	OBG	134	ROSE, ROBT, E, P O BOX 271 SPENCER 47460	GP	214
ROGERS, ROBT, SHIRRELL, 1101 S 6TH ST TERRE HAUTE 47802	GP	298	ROSEN, IRWIN, CHAS, 1941 VIRGINIA AVE CONNERSVILLE 47331	AN	074
ROGERS, THOS, PERRETTE, 6142 LA PINTURA DR LA JOLLA CA 92037	P	134	ROSENBAUM, IRVING, 401 E 34TH ST INDIANAPOLIS 46205	PD	134
ROGGE, JAMES, DELBERT, 1500 ALBANY AVE SUITE 808 BEECH GROVE 46107	NM	134	ROSENBAUM, LLOYD, E, 647 CITIZEN BK BLDG ANDERSON 46016	CD	186
ROGGENKAMP, MILTON, W, 144 ARROWHEAD DR WEST LAFAYETTE 47906	PTH	286	ROSENBLATT, BERNARD, B, 502 HULMAN BUILDING EVANSVILLE 47708	GP	296
ROHN, ROBT, J, 1100 W MICHIGAN ST INDIANA UNIV MEDICAL CENTER INDIANAPOLIS 46202	HEM	134	ROSENBLOOM, PHILIP, JACK, 1745 NORTH MANSORD BLVD GRIFFITH 46319	PH	174
ROHRER, BRYCE, BARTON, 506 MICHIGAN ST WALKERTON 46574	FP	258	ROSENE, HAROLD, A, 25 WOODRIDGE DR TERRE HAUTE 47803	GRS	298
ROIG, JOSE, HUGO, 500 WEST LINCOLN HWY MERRILLVILLE 46410	OPH	174	ROSENHEIMER, GEO, MILTON, 1425 EAST WOODSIDE ST SOUTH BEND 46614	AN	258
ROLD, JAMES, F, 2029 WASHINGTON AVE EVANSVILLE 47714	R	296	ROSENWASSER, JACOB, 834 LINCOLN WAY EAST MISHAWAKA 46544	IM	258
ROLLER, MAC, C, 1551 N MAIN ST FRANKLIN 46131	FP	158	ROSS, BEN, RICHARDSON, R R 1 BOX 149 BLOOMINGTON 47401	DS	214
ROLLINS, THOS, K, 822 WEST FIRST ST SUITE 3 BLOOMINGTON 47401	FP	214	ROSS, DAVID, EUGENE, 2318 W 5TH AVE GARY 46404	GP	174
ROMAIN, LOUIS, FRANK, 3124 E STATE BLVD STE 13 FORT WAYNE 46805	N	082	ROSS, EDWARD, 3901 N MERIDIAN ST SUITE 442 INDIANAPOLIS 46208	CD	134

ROSS, GLENN, ELRICK, 1210 BEDFORD RD WASHINGTON 47501	GER	046	ROWE, GEO, ANTHONY, 9002 MUD CREEK ROAD INDIANAPOLIS 46256	PDS	134
ROSS, GUY, EVERETT, 1931 BROWN ST ANDERSON 46014	PD	186	ROYSTER, ROBT, A, 34 JOHNSON PLACE EVANSVILLE 47714	GS	296
ROSS, STEVEN, EDWARD, 3217 LAKE AVE FORT WAYNE 46805	FP	082	RUBENS, ELI, 101 BEN FRANKLIN DR SARASOTA FL 33577	PDA	258
ROTH, BERTRAM, STANLEY, 6434 NORTH COLLEGE AVE INDIANAPOLIS 46220	PD	134	RUBIN, SIMON, SYRIL, TWIN TOWERS S SUITE 527S MERRILLVILLE 46410	A	174
ROTH, JAMES, ROBT, WOLFLAKE 46796	GP	326	RUBUSH, JOHN, LANCE, 919 EAST JEFFERSON BLVD SOUTH BEND 46622	TS	258
ROTH, LEO, 3229 BROADWAY GARY 46409	ORS	174	RUDDELL, KEITH, RICHARD, 1201 GOLDEN HILL DRIVE INDIANAPOLIS 46208	GS	134
ROTHBAUM, DONALD, ALAN, 8402 HARCOURT ROAD #713 INDIANAPOLIS 46260	IM	134	RUDESILL, ROBT, LOUIS, 3266 N MERIDIAN ST INDIANAPOLIS 46208	IM	134
ROTHENBERG, JERRY, 600 MARY STREET EVANSVILLE 47710	PTH	296	RUDICEL, MAX, HURD, 2423 W JACKSON ST MUNCIE 47303	FP	062
ROTHMAN, PETER, MITCHELL, 327 W CREIGHTON AVE FORT WAYNE 46807	PDA	082	RUDICEL, MAX, W, 1907 W SYCAMORE ST KOKOMO 46901	PTH	126
ROTHROCK, PHILIP, WAYNE, 2200 SCOTT ST LAFAYETTE 47904	IM	286	RUDOLPH, KENNETH, JACOB, 3700 BELLEMEADE EVANSVILLE 47715	OPH	296
ROTMAN, HARRY, GENE, 111 E MAIN ST BOX 185 JASONVILLE 47438		102	RUDOLPH, ROSSER, A, RR 4 BOX 356 MUNCIE 47302	CLP	146
ROTMAN, SAM, ISSAC, P O BOX 127 JASONVILLE 47438	GP	102	RUDSER, DONALD, HARRY, 2075 INDIANAPOLIS BLVD WHITING 46394	GP	174
ROUEN, ROBT, LESTER, 1209 HARRISON ST ELKHART 46514	OPH	070	RUDWELL, GEO, HENDERSON, 200 LONGVIEW DR JEFFERSONVILLE 47130	OTO	034
ROUHANA, RODOLPH, 7347 HAMSTEAD LANE INDIANAPOLIS 46256	FP	134	RUDY, DONALD, BYRON, PO MNENE VIO BELINGW RHODESIA AFRICA 60775	GP	318
ROURKE, ROBT, F, 631 S 25TH ST TERRE HAUTE 47803	OBG	298	RUFF, JERARD, GOEKE, 413 WEST FIRST ST BLOOMINGTON 47401	PD	214
ROUSHDI, HUSSEIN, ALI, 1213 ARLINGTON INDIANAPOLIS 46219	GS	134	RUIZ, CARLOS, MEDINA, 123 S SECOND ST BOONVILLE 47601	GP	306
ROUSSEAU, JOHN, WM, 2410 COLISEUM BLVD N FORT WAYNE 46805	OBG	082	RULE, NED, PERRY, 611 HARRIETT ST EVANSVILLE 47710	U	296
ROW, GEO, SAML, 121 W RIPLEY OSGOOD 47037	GP	250	RUMANA, ROBT, HENRY, 303 S MAIN ST BLUFFTON 46714	IM	318

RUNGE, PAUL, WM, 100 N 15TH ST RICHMOND 47374	IM	314	RYAN, C, DAVID, 2040 DOCTORS PARK COLUMBUS 47201	OBG	C14
RUOFF, WM, F, 1349 GRABLE COURT NEW ALBANY 47150	IM	078	RYAN, GLEN, V, 3500 LAFAYETTE RD INDIANAPOLIS 46222	GP	134
RUPE, LLOYD, O, 211 S 5TH ST ELKHART 46514	GS	070	RYAN, HUBERT, JOS, 826-9TH NEW SMYRNA BEACH FL 32069	PD	174
RUSCHE, HENRY, J, 313 W IOWA ST EVANSVILLE 47710	GP	296	RYAN, MICHAEL, GERAFO, 722 W MAIN ST MADISON 47250	FP	150
RUSCHE, HERMAN, FREDERICK, 3700 BELLMEADE AVE EVANSVILLE 47715	GE	296	RYAN, WM, JOHN, DOCTORS PARK COLUMBUS 47201	GS	C14
RUSCHE, THOS, JEROME, 1421 N MAIN ST EVANSVILLE 47711	N	296	RYU, CHI, YOL, 1100 W MICHIGAN ST INDIANAPOLIS 46202	DR	134
RUSCHLI, EDWARD, BARNARD, 604 KOSSUTH ST LAFAYETTE 47905	GP	286			
			5		
RUSHER, MERRILL, W, 347 W BERRY ST FORT WAYNE 46802	GYN	082	SAAVEDRA, BERNARDO, 8 GARFIELD VALPARAISO 46383	NS	174
RUSHMORE, CHAS, HENRY, 240 N MERIDIAN ST RM 354 INDIANAPOLIS 46204	OM	134	SABENS, JAMES, ALBERT, 8375 PENDLETON PIKE APT 500 INDIANAPOLIS 46226	FP	134
RUSK, BARTON, JAY, 8402 HARCOURT RD INDIANAPOLIS 46260	PUD	134	SABO, WILLIAM, J, 800 MACARTHUR BLVD SUITE 8 MUNSTER 46321	ORS	174
RUSK, HUBERT, MORGAN, BOX 36 WALLACE 47988	GP	086	SACRIS, MARIA, ORCHID M, 802 LAPORTE AVENUE VALPARAISO 46383	OBG	230
RUSSELL, CALVIN, R R 13 MUNCIE 47302	PM	062	SAFAYAN, ESFANDIAR, 221 S 6TH ST TERRE HAUTE 47801	OTO	298
RUSSELL, DONALD, E, 3500 LAFAYETTE RD INDIANAPOLIS 46222	OKS	134	SAFIRSTEIN-ROSZERMAN, M, 105 THREE RIVERS N FORT WAYNE 46802	AN	082
RUSSELL, JOHN, ROBT, 1815 N CAPITOL AVE INDIANAPOLIS 46202	NS	134	SAGALOWSKY, ARTHUR, I, 1113 NAVAJO TRAIL S DRIVE INDIANAPOLIS 46260	U	134
RUSSO, ANDREW, ESCHER, 12110 GRANT ST CROWN POINT 46307	GP	174	SAGALOWSKY, HOWARD, SIDNEY, 1815 N CAPITOL AVE INDIANAPOLIS 46202	AN	134
RUST, BYRON, KENNETH, 1325 HIDDEN HARBOR WAY SARASOTA FL 33581	PD	134	SAGE, CHAS, VICTOR, 48 S 11TH ST RICHMOND 47374	OS	314
RUST, ROLAND, B, 5626 EAST 16TH ST SUITE 21 INDIANAPOLIS 46218	IM	134	SAHLMANN, HANS, 2402 WOODWARD FORT WAYNE 46805	GP	082
RUTHERFORD, CHAS, E, 2315 S ST LAFAYETTE 47904	GS	286	SAINE, BRIAN, DAVID, 810 EAST COLFAX SOUTH BEND 46617	OTO	258

SALA, JOS, JOHN, 5490 BROADWAY L-16 MERRILLVILLE 46410	GP	174	SANDERS, FRED, 2702 WESTLANE RD INDIANAPOLIS 46268	GP	134
SALA, WALTER, RUDOLPH, 5490 BROADWAY L-16 MERRILLVILLE 46410	GP	174	SANDERS, HARRY, MUNFORD, COMMUNITY HOSPITAL INDIANAPOLIS 46219	GP	134
SALAMA, FAWZY, EL-SAYED, 317 LOGWOOD EVANSVILLE 47710	U	296	SANDERSON, ROBT, BURNS, 238 S HAWTHORNE SOUTH BEND 46617	PUD	258
SALAZAR, LUIS, BARBA, 3120 RUE RENOIR APT 205 SOUTH BEND 46615	GE	258	SANDLIN, DONALD, LEE, 2127 DOCTORS PARK DR COLUMBUS 47201	FP	014
SALB, JOHN, PAUL, 721 WEST 13 JASPER 47546	GP	066	SANDOCK, LOUIS, F, 503 SHERLAND BLDG SOUTH BEND 46601	IM	258
SALEH, IBRAHIM, MITRE, 6111 HARRISON ST MERRILLVILLE 46410	OBG	174	SANDOCK, MARK, STEVEN, 818 SHERLAND BLDG SOUTH BEND 46601	IM	258
SALES, AVELINO, T, 12103 WINDSOR DR CARMEL 46032	AN	134	SANDOZ, HARRY, H, 2500 TOPSFIELD RD SOUTH BEND 46614	GP	258
SALISBURY, CHAS, PARSON, 1024 S 6TH SUITE 205 TERRE HAUTE 47807	OBG	298	SANKEY, PEGGY, LOU, 1021 S 6TH ST TERRE HAUTE 47807	PTH	298
SALOMON, JAIME, A, 8739 SAWLEAF INDIANAPOLIS 46260	GPM	134	SANTARE, VINCENT, JOS, 513 RIDGE RD MUNSTER 46321	U	174
SALON, HARRY, W, 4017 HIAWATHA BLVD FORT WAYNE 46807	GP	082	SANTOS, FRANCISCO, 1815 N CAPITOL INDIANAPOLIS 46202	AN	134
SALON, JOEL, WARREN, 604 W WAYNE ST FORT WAYNE 46802	IM	082	SAPERSTEIN, MORRIS, 110 LAKEVIEW DRIVE NOBLESVILLE 46060	CHP	106
SALSBERG, HERBERT, E, R R 1 BOX 355 HAMLET 46532	P	178	SARKAR, ANIL, K, 320 N SECTION ST SULLIVAN 47882		282
SALVO, ATEE, SEVILLA, 403 NORTH MONROE WILLIAMSPORT 47993	AN	086	SARKAR, DIPPA, 1206 EAST NATIONAL AVE BRAZIL 47834		038
SAMADDAR, PRASOON, KUMAR, 2900 WEST 16TH ST BEDFORD 47421	OTO	182	SARTORE, GILBERT, ALLAN, 801 ST MARYS DR SUITE 200 EVANSVILLE 47715	FP	296
SAMALIO, JUSTO, R, BOX 95 MICHIGAN CITY 46360	AN	178	SATO, TAKUYA, 4475 CLOVER LAKE DR INDIANAPOLIS 46208	CHP	134
SAMI, ABDEL, W, 2900 WEST 16TH ST BEDFORD 47421	PTH	182	SAUER, JOHN, BERNARD, 3655 S SHERMAN DR BEECH GROVE 46107	GP	134
SANCHEZ, JOSE, DOLORES, P O BOX 211 LA PORTE 46350	AN	178	SAWYER, DOUGLAS, EARL, 3217 LAKE AVE FORT WAYNE 46805	FP	082
SANDERS, BERTRAM, WEBB, 634 EASTERN AVE CONNEERSVILLE 47331	GP	074	SCALES, ALLEN, DEARING, LELAND HEIGHTS HUNTINGBURG 47542	GP	066

SCAMAHORN, JAMES, OSCAR, 34 WEST MAIN STREET PITTSBORO 46167		118	SCHEIDLER, JAMES, A, 3421 BRECKERIDGE DR INDIANAPOLIS 46208	IM	134
SCAMAHORN, MALCOLM, O, MAIN AT MEREDIAN PITTSBORO 46167	FP	118	SCHEIER, EMIL, WM, 9220 VANDERGRIFF RD INDIANAPOLIS 46239	OS	134
SCANLON, JOHN, CHAS, 2600 GREENBUSH ST LAFAYETTE 47904	PUD	286	SCHEIMANN, LOIS, A GRIEDER, 702 LINCOLNWAY VALPARAISO 46383	A	230
SCEA, WALLACE, A, 1600 S ANDERSON ST ELWOOD 46036	GP	186	SCHELL, HARRY, RICHARD, 711 W 2ND ST BLOOMINGTON 47401	OBG	214
SCHAAB, ERIC, 131 E TILLMAN RD FORT WAYNE 46806	PD	682	SCHEN, SANFORD, ELLIOTT, 421 CHESTNUT ST EVANSVILLE 47713	IM	296
SCHAAF, ALVIN, DAVID, 33 S WALNUT ST JAMESTOWN 46147	GP	022	SCHENCK, RALPH, E, 603 W ARCH ST PORTLAND 47371	ORS	146
SCHAFER, WM, CHAS, 1312 BEDFORD RD WASHINGTON 47501	OPH	046	SCHERB, BURTON, E, 1024 S 6TH ST TERRE HAUTE 47807	OPH	298
SCHAFER, EDWARD, V, 5626 EAST 16TH ST NO 13 INDIANAPOLIS 46218	ORS	134	SCHERER, JACK, ROGER, TIPTON PARK PLAZA 360-C PLAZA DRIVE COLUMBUS 47201	D	014
SCHAFER, JAMES, JOHANNES, 717 W 1ST ST BLOOMINGTON 47401	PD	214	SCHERSCHER, THOS, ROGER, 3423-B S LAFOUNTAIN KUKOMO 46901	GS	126
SCHALLIOL, JAMES, PAUL, ROOM 107 KNAPP BLDG ROCHESTER 46975	P	090	SCHEURICH, MANLEY, KING, RR 1 OXFORD 47971	FP	018
SCHAPHORST, RICHARD, A, 612 N MAIN ST MISHAWAKA 46544	GP	258	SCHEURICH, VIRGIL, OXFORD 47971	GS	018
SCHAROFF, JAY, ROBT, 600 GRANT ST GARY 46402	NM	174	SCHILLER, HERBERT, A, 919 E JEFFERSON BLVD SOUTH BEND 46622	OBG	258
SCHAUWECKER, CLEON, M, 239 HILLSDALE AVE GREENCASTLE 46135	GS	242	SCHILLING, RICHARD, J, 711 W 2ND ST BLOOMINGTON 47401	GS	214
SCHECHTER, JOHN, S, 3266 N MERIDIAN ST INDIANAPOLIS 46208	IM	134	SCHIMMELPFENNIG, ROBT, WM, 1013 PARRETT ST EVANSVILLE 47713	PD	296
SCHECHTER, JOHN, STEPHEN, 413 W FIRST AVE BLOOMINGTON 47401	PD	214	SCHIRMER, ROBT, H, 1118 W FRANKLIN ST EVANSVILLE 47710	GP	296
SCHEER, ALEXANDER, L, ELKHART CLINIC BOX 2507 ELKHART 46514	OTO	070	SCHLADEMAN, KARL, R, P O BOX 268 FORT WAYNE 46801	PTH	082
SCHEERES, JACOB, WM, 2315 SOUTH ST LAFAYETTE 47905	GS	286	SCHLAEGEL, THEODORE, F, 1100 W MICHIGAN ST INDIANAPOLIS 46202	OPH	134
SCHEERINGA, RONALD, HENRY, 2828 FAIRFIELD AVE FORT WAYNE 46807	IM	082	SCHLEGEL, DONALD, M, 1815 N CAPITOL AVE INDIANAPOLIS 46202	GS	134

SCHLEINKOFER, ROBT, MELVIN, 3217 LAKE ST FORT WAYNE 46805	GP	082	SCHNUTE, RICHARD, B, INDIANA UNIV SCH MED INDIANAPOLIS 46202	END	134
SCHLESINGER, DANL, J, 6633 FOREST HAMMOND 46324	GS	174	SCHOEN, FREDERIC, L, DEPT FAMILY MED LONG 217 1100 WEST MICHIGAN ST INDIANAPOLIS 46202	FP	134
SCHLOSSBERG, VICTOR, E, 301 W 4TH ST MISHAWAKA 46544	IM	258	SCHOENHALS, CHAS, ERB, 5050 N CLINTON FORT WAYNE 46825	GS	082
SCHMALHAUSEN, ANSEL, WAYNE, 6227 HILLCREST LN INDIANAPOLIS 46220	GS	134	SCHOULFIELD, WM, EARL, 26C S MAPLE ST ORLEANS 47452	GP	210
SCHMALZ, WM, JUSTIN, ST JOHNS MED ARTS BLDG 2101 JACKSON ST ANDERSON 46014	IM	186	SCHOONVELD, ARTHUR, 420 EAST MAIN ST BROOK 47922	GP	204
SCHMETZER, ALAN, DAVID, 1500 ALBANY ST SUITE 907 BEECH GROVE 46107	P	134	SCHREINER, JOHN, EDWARD, 201 E PLYMOUTH BREMEN 46506	GP	190
SCHMIDT, EUGENE, EDWARD, 5800 FAIRFIELD AVE FORT WAYNE 46807	AN	082	SCHREPFERMAN, WAYNE, HAMILTON 46742	GP	278
			SCHRIEFER, VICTOR, V, 2845 RAVENSWOOD EVANSVILLE 47714	GP	296
			SCHRODER, LOUIS, E, 313 EAST UNION ST LIBERTY 47353	FP	314
SCHMIDT, PAUL, EDGAR, 3266 N MERIDIAN ST NO 701 INDIANAPOLIS 46208	CD	134	SCHROEDER, HENRY, R, 611 HARRIET SUITE 206 EVANSVILLE 47710	CBG	296
SCHMIEDICKE, PAUL, HENRY, 112 WHEELER LANE WEST LAFAYETTE 47906	IM	286	SCHROEDER, JAMES, EDWIN, 3524 N MERIDIAN ST INDIANAPOLIS 46208	HEM	134
SCHMITT, RICHARD, K, 2639 RIVERSIDE DR COLUMBUS 47201	GP	014	SCHUBERT, JEROME, C, 5110 N CLINTON FORT WAYNE 46825	GP	082
SCHMITT, ROBT, J, 7905 CALUMET AVE MUNSTER 46321	P	174	SCHUBERT, PHILIP, CHANDLER, 6203 PLANTATION LANE FORT WAYNE 46805	GP	082
SCHMOLL, ROBT, J, 521 W WAYNE ST FORT WAYNE 46802	OPH	082	SCHULFER, RICHARD, J, 7134 CALUMET AVE HAMMOND 46324	GP	174
SCHNEIDER, CARL, JOS, 4819 ROUND LAKE RD INDIANAPOLIS 46205	GP	134	SCHULZ, KURT, J E, 800 CLINIC CIRCLE FAIRMONT MN 56031	OPH	174
SCHNEIDER, CHAS, P, 2912 W MARYLAND ST EVANSVILLE 47712	GP	296	SCHUMACHER, RICHARD, R, 3524 N MERIDIAN ST INDIANAPOLIS 46208	CD	134
SCHNEIDER, KENNETH, DALE, 2760 25TH ST COLUMBUS 47201	AN	014	SCHUMAKER, ROBT, A, 3050 POPLAR ST TERRE HAUTE 47803	GP	298
SCHNEIDER, LAWRENCE, F, 3217 LAKE AVE FORT WAYNE 46805	FP	082	SCHUSTER, DWIGHT, WM, 1815 NORTH CAPITOL AVE INDIANAPOLIS 46202	P	134
SCHNEIDER, LOUIS, A, 700 BROADWAY FORT WAYNE 46802	PTH	082			

SCHWARTZ, JACK, 7550 HOHMAN AVE MUNSTER 46321	OBG	174	SCULLY, JOHN, T, 6111 HARRISON AVE MERRILLVILLE 46410	IM	174
SCHWARTZ, MAGDA, 7315 FOREST AVE HAMMOND 46324	AN	174	SCULLY, WM, EDWARD, 221 S 6TH ST TERRE HAUTE 47801	PC	298
SCHWARTZBERG, STUART, G, 5717 S ANTHONY BLVD FORT WAYNE 46806	GS	082	SCUPHAM, WM, KENT, 900 I ST LA PORTE 46350	IM	178
SCHWARZ, ANTON, JOS, 1911 EASTLAWN APT E-5 MIDLAND MI 48640	IM	134	SCUZZO, VINCENT, C, 214 SHERLAND BLDG SOUTH BEND 46601	CRS	258
SCOFIELD, JOHN, B, 3120 MERIDIAN ST INDIANAPOLIS 46208	F	134	SEAGLE, WM, COURTNEY, 111 E 9TH ST BLOOMINGTON 47401	ORS	214
SCOTT, FRANK, M, 211 N EDDY AT COLFAX SOUTH BEND 46617	GS	258	SEAL, PERRY, FRANCIS, 901 N MAIN ST BROOKVILLE 47012	GP	074
SCOTT, GEO, EVERETT, 4110 ROLAND RD INDIANAPOLIS 46208	AN	134	SEAMAN, CHAS, FRANCIS, 4725 COVE CIRCLE NO 810 ST PETERSBURG FL 33708	EM	134
SCOTT, H, VAUGHN, 801 E STATE ST FORT WAYNE 46805	PD	082	SEARIGHT, HOWARD, R, 3111 WEST JACKSON MUNCIE 47304	OTO	062
SCOTT, IVAN, WINFIELD, 6106 RIVERVIEW DR INDIANAPOLIS 46208		134	SEARS, DON, ALVIN, 508 W ELNOKA ODON 47562	GP	046
SCOTT, JOHN, RICHARD, 6214 BROADWAY INDIANAPOLIS 46220	PD	134	SEAT, MARSHALL, H, 1400 GRAND AVE WASHINGTON 47501	GP	040
SCOTT, JOHN, SPAHR, 806 MAPLE AVE LA PORTE 46350	K	178	SEBAHAR, DUANE, ALLEN, 2760 25TH ST COLUMBUS 47201	IM	014
SCOTT, PETER, L, 10184 PARTRIDGE PLACE CARMEL 46032		134	SEDAM, HERBERT, L, 4548 N COLLEGE AVE INDIANAPOLIS 46205	GP	134
SCOTT, SAML, LOGAN, 7099 BROADWAY INDIANAPOLIS 46220	GS	134	SEESE, ROBT, M, 101 W NORTH ST DELPHI 46923	GP	026
SCOTT, V, BROWN, R R 2 BOX 11 SHELBYVILLE 46176	IM	266	SEIBEL, ROBT, MARVIN, BOX 127 NASHVILLE 47448	GP	014
SCOTT, WM, MOUNT, P O BOX 4399 SCOTTSBURG 47170	GP	262	SEIPEL, STANLEY, F, LANESVILLE 47136	GP	114
SCUDDER, ARTHUR, NELSON, 24 N GRANT ST BROWNSBURG 46112	GP	118	SEKULICH, MILO, M, ST JOSEPH HOSP KOKOMO 46901	R	126
SCUDDER, GARY, EVANS, 370 BIELBY RD LAWRENCEBURG 47025	GP	050	SELLMER, GEO, WM, 1221 E 86TH ST INDIANAPOLIS 46240	GP	134
SCUDDER, JAMES, PETERSON, 3124 E STATE ST FORT WAYNE 46805	U	082	SEMEKDJIAN, ARAM, 540 TYLER ST GARY 46402	R	174

SENN, RICHARD, THOS, 1716 SOUTH PLATE KOKOMO 46901	U	126	SHANKLIN, VERNON, A, 15 CIRCLE DR TERRE HAUTE 47803	GP	298
SENTANY, MARKI, S, 1145 FIESTA DR GREENWOOD 46142	PS	134	SHANKS, RAY, W, 1148 LUCERNE PKWY CAPE CORAL FL 33904	GP	106
SER VAAS, CORENA, SYNHORST, 1100 WATERWAY BLVD INDIANAPOLIS 46202	OS	134	SHANNON, WESLEY, EUGENE, 215 N WARD ST CRAWFORDSVILLE 47933	GP	198
SERA, SEGUNDO, R, 2900 W 16TH ST BEDFORD 47421	PD	182	SHAPIRO, BURTON, J, 3620 N MERIDIAN INDIANAPOLIS 46208	OPH	134
SERNA, CARLOS, A, 2342 RIDGE RD HIGHLAND 46322	IM	174	SHAPIRO, JOS, 4214 PARRISH AVE EAST CHICAGO 46312	GP	174
SERRANO, EDWARD, 622 NORTH MADISON ST GREENWOOD 46142	EM	134	SHAPIRO, SEYMOUR, WM, 6400 152 CT LOWELL 46356	GS	174
SERRANO, JOSE, FLORENTINO, 57 CLINTON HAMMOND 46320	ABS	174	SHARP, GARY, CHAS, 120 WEST MC KENZIE RD GREENFIELD 46140	GP	110
SEXSON, HIRAM, TETRICK, 3201 N MERIDIAN ST INDIANAPOLIS 46208	GP	134	SHARP, MERLE, CALVIN, 912 E LA SALLE AVE SOUTH BEND 46617	OBG	258
SHAFFER, MARION, RUSSELL, 115 NORTH PENN ST INDIANAPOLIS 46204	IM	134	SHARP, THUS, WAYNE, 2920 RAMBLE RD WEST BLOOMINGTON 47401	GP	214
SHAFFER, RICHARD, H, 111 S HARRISON ST ALEXANDRIA 46001	GP	186	SHARP, WM, LELAND, 559 CITIZENS BANK BLDG ANDERSON 46016	P	186
SHAFER, KENNETH, LEE, 302 MAIN ST VINCENNES 47591	OPH	162	SHATTUCK, JOHN, CHAS, 11 WEST CHESTNUT ST BRAZIL 47834	GP	038
SHAH, AJIT, 702 RIVER DR MARION 46952	OBG	098	SHAW, GLENN, ROBT, 303 S MAIN ST BLUFFTON 46714	OBG	318
SHAH, KISHORI, P, 1159 ETNA AVE HUNTINGTON 46750	OBG	130	SHEEHAN, E, GREGG, 421 CHESTNUT ST EVANSVILLE 47713	OBG	296
SHAH, PIYUSH, J, 1159 ETNA AVE HUNTINGTON 46750	PD	130	SHEEHAN, FRANCIS, G, 8436 BROWNING DR NO E INDIANAPOLIS 46227	EM	134
SHAHBAHKAMI, FARROKH, 619 W 1ST ST BLOOMINGTON 47401	GS	214	SHEELER, GARY, LEE, 3217 LAKE AVE FORT WAYNE 46805	FP	062
SHALLENBERGER, HENRY, R, MODOC 47358	FP	246	SHELDON, SUEL, A, 508 ANDERSON BANK BLDG ANDERSON 46016	D	186
SHANAFELT, DONALD, K, 5471 E 77TH ST INDIANAPOLIS 46250	OBG	134	SHELLEY, EDWARD, S, 207 S TAYLOR ST SOUTH BEND 46625	GP	258
SHANKLIN, JACK, LESLIE, 702 VIGO ST VINCENNES 47591	GP	162	SHELLEY, RICHARD, JOS, 5470 E 16TH ST INDIANAPOLIS 46218	OBG	134

SHELTON, CLYDE, F, 1726 STATE ST NEW ALBANY 47150	PD	078	SHOLTY, WM, MAXWELL, 1831 LILLY ROAD LAFAYETTE 47905	AN	286
SHELTON, N, PHILIP, 621 S 7TH ST VINCENNES 47591	FP	162	SHORT, JOHN, A, 4284 SOUTH C COURT RICHMOND 47374	AN	314
SHERER, KENNETH, E, P O BOX 249 RICHMOND 47374	AN	314	SHOWALTER, JOHN, RALPH, 1233 MAPLE AVE TERRE HAUTE 47804	GP	298
SHERMAN, DAVID, EMERY, 2406 FERRY ST LAFAYETTE 47904	DBG	286	SHRIBER, WM, HOWARD, 211 N EDDY AT COLFAX SOUTH BEND 46617	DBG	258
SHERSTER, HARRY, 2459 SHELBY ST NO 1 % IRENE PATTERSON INDIANAPOLIS 46203	GP	134	SHRINER, PHILIP, OWEN, 3124 EAST STATE BLVD NO 19-21 FORT WAYNE 46805	U	082
SHERWOOD, CLARENCE, E, 1504 5TH ST SOUTH BROOKINGS SD 57006	GS	082	SHRINER, WILLIAM, CUPPY, 620 8TH AVE TERRE HAUTE 47804	P	298
SHERWOOD, J, VINCENT, 200 STARCREST DR APT NO 317 CLEARWATER FL 33515	PUD	082	SHROCK, ETHAN, ELLSWORTH, AMBOY 46911	GP	098
SHETTY, DAYANANDA, M, 1814 ORIOLE DR MUNSTER 46321	OTO	174	SHROYER, HERBERT, L, 303 S MAIN ST BLUFFTON 46714	GP	318
SHEVICK, ALEXANDER, 846 LINCOLNWAY VALPARAISO 46383	DBG	230	SHUCK, WILLIAM, ARTHUR, 1251 KEM RD MARION 46952	GS	098
SHIELDS, DUNCAN, MC ELROY, 219 DOGWOOD DR CHESTERTON 46304	OM	230	SHUCK, WM, ARTHUR, 414 N MULBERRY ST MADISON 47250	GS	150
SHIELDS, JACK, EMERSON, 603 W SPRING ST BROWNSTOWN 47220	GP	138	SHUGART, ROBERT, R, 2609 FAIRFIELD AVE FORT WAYNE 46807	ORS	082
SHINA, HASSI, CHARLESTOWN LANDING RD CHARLESTOWN 47111	GP	034	SHULRUFF, HARRY, I, 3701 MAIN ST EAST CHICAGO 46312	OPH	174
SHINABERY, LAWRENCE, 212 THREE RIVERS NORTH FORT WAYNE 46802	GP	082	SHULTZ, CLIFFORD, JAMES, R D 1 BOX 126 BUTLER 46721	GP	058
SHINN, GLORIA, LOU, 303 S MAIN ST BLUFFTON 46714	GS	318	SHUMACKER, HARRIS, B, 8402 HARCOURT RD STE 411 INDIANAPOLIS 46260	CDS	134
SHIPLEY, EDWARD, CHAS, 2010 W 86TH ST SUITE 205 INDIANAPOLIS 46260	CHP	134	SIBBITT, JOS, WM, 115 S LINCOLN BLOOMINGTON 47401	OTO	214
SHIRAZI KESHAVARZ, E, 2000 WEST MAIN ST NO E RICHMOND 47374	OTO	314	SICKS, OKLA, WILBUR, 1970 HAMILTON LANE CARMEL 46032	GS	134
SHIVELY, JOHN, L, 2525 SOUTH ST LAFAYETTE 47904	ORS	286	SIDEL, ALAN, WAYNE, 5110 N CLINTON FORT WAYNE 46825	GP	082
SHOEMAKER, RICHARD, L, 212 EAST NORTH C ST GAS CITY 46933	GP	098	SIDELL, JAMES, PAUL, 1208 LINCOLN HWY E NEW HAVEN 46774	GP	082

SIDERY, HARRY, 1815 N CAPITAL AVE-507 INDIANAPOLIS 46202	TS	134	SINGCO, BIENVENIDO, O, 1513 BRUNNER DR GREENFIELD 46140	FP	110
SIEBE, JACK, CHAS, 958 GOVERNORS COURT MOBILE AL 36609	GP	134	SINGER, MARK, I, 2074 LANDMARK DRIVE NO 904 INDIANAPOLIS 46260	OTO	134
SIEBENMORGEN, PAUL, 1024 S 6TH ST TERRE HAUTE 47807	GP	298	SINGH, CHANDRABHAN, JOHNSON CO HOSP PATH DEPT FRANKLIN 46131	PTH	158
SIEGEL, LYLE, PHILLIP, 7091 E CHERRY ST EVANSVILLE 47715	AN	296	SINGH, URMILA, 6919 EAST TENTH INDIANAPOLIS 46219	PD	134
SIEKIERSKI, JOS, M, 145 N GRIFFITH BLVD GRIFFITH 46319	FP	174	SINKOVIC, GERALD, MATHIAS, 25 BEACHWAY DR INDIANAPOLIS 46224	GP	134
SIGMOND, HARVEY, W, 8402 HARCAOURT RD APT 805 INDIANAPOLIS 46260	ORS	134	SINN, CHAS, M, 515 READ ST EVANSVILLE 47710	IM	296
SIGMUND, WM, BELMER, PO BOX 366 COLUMBUS 47201	U	014	SIRLIN, EDWARD, MARTIN, 5248-6 STONEHEDGE BLVD FORT WAYNE 46815	PD	082
SILBERT, MICHAEL, ZALMAN, 822 W 1ST ST SUITE 4 BLOOMINGTON 47401	GS	214	SIRUGO, ALDO, CORRADO, 6916 W JOHNSON RD LA PORTE 46350	OTO	178
SILBERT, ROBT, KIM, 3351 NORTH MERIDIAN ST INDIANAPOLIS 46208	PM	134	SISON, EDUARDO, VENTENILLA, 2105 OLD OAK DR VALPARAISO 46383	GP	230
SILVA, CARLOS, A, 503 E NATIONAL AVE SUITE A INDIANAPOLIS 46227	GS	134	SISON, VICENTE, G, 2929 S 1ST ST TERRE HAUTE 47802		298
SILVER, RICHARD, ARNOLD, 1114 FREDRICK DR SOUTH INDIANAPOLIS 46260	R	134	SKAGGS, HOMER, RR NO 5 FLEENER EVANSVILLE 47711	EM	296
SILVERMAN, NORMAN, M, 1142 S CENTER TERRE HAUTE 47802	P	298	SKIDMORE, CHAS, EDWARD, 128 WEST MARKET ST WOLCOTT 47995	GP	286
SILVERO, HUBERT, L, 1417 N ANTHONY BLVD FORT WAYNE 46805	GP	082	SKILES, MELVIN, JAMES, 134 PARKVIEW DR MAISON 47250	DR	150
SILVERS, L, MICHAEL, 1104 N WAYNE NORTH MANCHESTER 46962	FP	302	SKILLERN, SCOTT, D, 722 E COLIFAX SOUTH BEND 46617	D	258
SIMMONS, FREDERICK, H, 1009 N BALDWIN AVE MARION 46952	OTO	098	SLAMA, GEO, FRANCIS, 6111 HARRISON ST MERRILLVILLE 46410	GE	174
SIMMONS, JAMES, EDWIN, 1100 W MICHIGAN ST INDIANAPOLIS 46202	CHP	134	SLAUGHTER, HOWARD, C, 1001 WALNUT ST EVANSVILLE 47708	OPH	296
SIMS, J, LAWRENCE, 3723 N GALE ST INDIANAPOLIS 46218	OTO	134	SLAUGHTER, JOHN, C, 3700 BELLEMEADE AVE EVANSVILLE 47715	D	296
SIMS, LARRY, WAYNE, 521 KIRKWOOD DR EVANSVILLE 47715	GP	296	SLAUGHTER, OWEN, LE ROY, R R 8 BROWNING RD 24 OAK MEADOW EVANSVILLE 47711	IM	296

SLICHENMYER, JACK, ELLIS, 3500 LAFAYETTE RD INDIANAPOLIS 46222	OTO	134	SMITH, HERSCHEL, S, 316 EAST 4TH ST P O BOX 667 BLOOMINGTON 47401	OPH	214
SLICK, CRYSTAL, RAY, 512 OAK ST WINCHESTER 47394	GP	246	SMITH, HOPE, C, 3566 W 71ST INDIANAPOLIS 46268	GP	134
SLOAN, W, KEITH, 426 E MAIN ST MADISON 47250	GS	150	SMITH, JAMES, WARREN, 1100 W MICHIGAN ST INDIANAPOLIS 46202	CLP	134
SLUSS, DAVID, H, 3657 WASHINGTON BLVD INDIANAPOLIS 46265	GS	134	SMITH, JERALD, E, 7905 CALUMET AVE MUNSTER 46321	FP	174
SMALL, IVER, FRANCIS, L D CARTER MEM HOSP INDIANAPOLIS 46202	P	134	SMITH, JERROLD, REX, 5430 E 21ST ST INDIANAPOLIS 46218	PD	134
SMEJKAL, JERALD, J, 6111 HARRISON ST MERRILLVILLE 46410	PS	174	SMITH, JOHN, ARTHUR, 1100 W MICHIGAN ST INDIANAPOLIS 46208	R	134
SMITH, A, WILSON, 1901 TAYLOR RD COLUMBUS 47201	IM	242	SMITH, JOHN, HAROLD, 144 GRANDISON RD GREENFIELD 46140	AN	110
SMITH, BARTON, TAYLOR, 702 RIVER RD MARION 46952	OBG	098	SMITH, JOHN, PAUL, 3217 LAKE AVENUE FORT WAYNE 46805	GP	082
SMITH, BERNARD, 1721 BROADWAY GARY 46407	IM	174	SMITH, KENNETH, ALLEN, 1804 N JEFFERSON ST HUNTINGTON 46750	IM	130
SMITH, CHAS, FELPS, HOWARD COMMUNITY HOSP KOKOMO 46901	R	126	SMITH, LE ROY, A, 1511 WABASH SUTE 15 MICHIGAN CITY 46360	ORS	178
SMITH, CLIFFORD, CURTIS, 5110 N CLINTON FORT WAYNE 46825	GP	082	SMITH, LEE, 1925 E JEFFERSON BLVD SOUTH BEND 46617	OPH	258
SMITH, DAVID, LESLIE, 5300 W 96TH ST INDIANAPOLIS 46268	OBG	134	SMITH, LOWELL, CLINE, 637 FERRY ST LAFAYETTE 47901	GP	286
SMITH, EVRETT, FRANK E, MARION GENERAL HOSP RAD DEPT WABASH AND EUCLID STREETS MARION 46952	R	098	SMITH, PHILIP, LE ROY, 2828 FAIRFIELD AVE FORT WAYNE 46807	OBG	082
SMITH, FRED, PROFESSIONAL BLDG TELL CITY 47586	GS	222	SMITH, RALPH, OGILVY, P O BOX 686 VINCENNES 47591	IM	162
SMITH, GORDON, LANE, 715 1ST AVE EVANSVILLE 47710	P	296	SMITH, RAY, C, 1303 N ARLINGTON AVE NO 4 INDIANAPOLIS 46219	GS	134
SMITH, H, CHAS, 303 S MAIN ST BLUFFTON 46714	PD	318	SMITH, ROBT, D, 1218 HILLTOP CT LOWELL 46356	GP	174
SMITH, HAROLD, EARL, MEADOWBROOK LANE R R 1-25 NEWBURGH 47630		296	SMITH, ROGER, CARLTON, 3124 E STATE ST FORT WAYNE 46805	IM	082
			SMITH, ROY, LEE, 407 N PENNSYLVANIA INDIANAPOLIS 46204	U	134

SMITH, STEWART, P, 801 ST MARYS DRIVE SUITE 501 EVANSVILLE 47715	NEP	296	SO, JAMES, L, 20400 ACHILLES-ARCADIA OLYMPIA FIELDS IL 60461	TS	174
SMITH, THEODORE, J, 1819 MID OCEAN CIRCLE SARASOTA FL 33580	OM	174	SOBAT, WILLIAM, SAMUEL, 1815 N CAPITOL R 304 INDIANAPOLIS 46202	GS	134
SMITH, WILBUR, L, 1100 W MICHIGAN INDIANAPOLIS 46202	DR	134	SOBOL, ZBIGNIEW, W, 328 N MICHIGAN ST SOUTH BEND 46601	ORS	258
SMUCKER, ERNEST, EDWARD, 112 S 5TH AVE GOSHEN 46526	GS	070	SOLIS, ROGER, VALBERG, 430 CONKEY ST HAMMOND 46324	OBG	174
SMUCKER, JON, E, 112 S 5TH ST GOSHEN 46526	GS	070	SOMANI, INDRA, KUMAR, 600 GRANT ST GARY 46402	PTH	174
SMYRNIOTIS, FOTIOS, E, 1251 KEM RD KEM VIEW MED CTR MARION 46952	GE	098	SONG, JOHN, YE KUN, 1344 TULIP LANE MUNSTER 46321	GP	174
SNEARY, MAX, EUGENE, 125 BAUM ST AVILLA 46710	GP	206	SONGER, JOS, MICHAEL, 3729 WEST JACKSON ST MUNCIE 47304	IM	062
SNELL, MALCOLM, SHERWOOD, 5354 N PARK AVE INDIANAPOLIS 46222	NS	134	SONNE, IRVIN, H, 1546 SUNSET DR NEW ALBANY 47150	R	078
SNIDER, BYRON, 16976 DOMINICAN DR SAN DIEGO CA 92128	US	134	SOPER, HUNTER, ALEXANDER, 3524 N MERIDIAN ST INDIANAPOLIS 46208	IM	134
SNIDER, DONALD, LESTER, P O BOX 517 VINCENNES 47591	GS	162	SORAK, KATICA, 7905 CALUMET MUNSTER 46321	DR	174
SNIDER, ROLAND, SIMPSON, 2235 DUBOIS ST WARSAW 46580	GP	166	SORG, DAVID, ARTHUR, 2325 SANTA ROSA DR FORT WAYNE 46805	END	082
SNIVELY, WM, DANL, RR 1 BOX 277 EVANSVILLE 47721	IM	296	SORIA-NAVARRO, CORAZON, E, 46 STONEGATE DRIVE STONEGATE PROFESSIONAL PLAZA INDIANAPOLIS 46227	OBG	134
SNODGRASS, ROBT, EUGENE, 532 TURTLE CREEK N DR STE A-1 INDIANAPOLIS 46227	P	134	SORRELLS, GEORGE, W, 2900 W 16TH ST BEDFORD 47421	PD	182
SNOWHITE, ARTHUR, B, 513 NORTH RIVER DRIVE MARION 46952	OPH	098	SOTOLONGO, ELADIO, 8807 STAGHORN RD INDIANAPOLIS 46260	AN	134
SNYDER, MORRIS, CLAYTON, 100 NORTH 15TH RICHMOND 47374	GP	314	SOUDER, BONNELL, MARIE, 206 W 7TH ST AUBURN 46706	A	058
SNYDER, PARKER, W, 302 N DUKE PERU 46970	FP	194	SOUDER, MARK, S, 3217 LAKE AVE FORT WAYNE 46805	FP	082
SNYDERMAN, SANFORD, CHAS, 102 MED CTR BLDG FORT WAYNE 46802	OTO	082	SOULE, MARY, A, 5214 BRIEF RUN INDIANAPOLIS 46226	OBG	134
			SOUTER, MARTHA, CHANDLEY, 5764 OAKLAND TERR APT C INDIANAPOLIS 46220	PD	134

SOUTH, DALE, R, SIMPSON AND SUPERIOR ELKHART 46514	FP	070	SPENCE, MICHAEL, B, 11807 EDEN ESTATES DRIVE CARMEL 46032	DR	134
SOUTH, TERRY, A, RK 5 BOX 287 EVANSVILLE 47711	GP	296	SPENCER, BEAUFORT, A, 110 E 10TH ST BLOOMINGTON 47401	A	214
SOVINE, JOE, W, 8182 NORTH ILLINOIS ST INDIANAPOLIS 46260	IM	134	SPENCER, C, HERBERT, 105 THREE RIVERS N FORT WAYNE 46802	AN	082
SOWA, ELIZABETH, LEE CLARK, 1015 HULMAN EVANSVILLE 47708	OPH	296	SPENCER, FREDERICK, 902 PERRY ST VINCENNES 47591	OBG	162
SOWA, RONALD, W, 611 HARRIETT ST EVANSVILLE 47710	ORS	296	SPICER, STEPHEN, CHARLES, 1103 EAST GRACE ST RENSSELAER 47978	FP	142
SPAHN, JAMES, GABRIEL, 314 S E RIVERSIDE EVANSVILLE 47713	OTO	296	SPINDLER, RICHARD, GILBERT, 300 NORTH TOWNLINE RD LAGRANGE 46761	OM	170
SPAHR, JOHN, FRANKLIN, 3014 GREEN HILLS LANE INDIANAPOLIS 46222	OBG	134	SPITZBERG, DANL, HARVEY, 10455 N COLLAGE AVE INDIANAPOLIS 46280	OPH	134
SPAIN, W, THOS, R R 1 BOX 34 NEWBURGH 47630	OBG	296	SPOLYAR, LOUIS, WM, 1330 W MICHIGAN ST INDIANAPOLIS 46202	PH	134
SPALDING, DAVID, LEE, 427 LINCOLN WAY EAST MISHAWAKA 46544	FP	258	SPRAY, PAGE, EDWARD, 320 W HIGH ST ELKHART 46514	GP	070
SPALDING, JOS, JOHN, 7290 N MERIDIAN ST INDIANAPOLIS 46260	OPH	134	SPRECHER, HERMAN, C, 5040 BELLEMEADE EVANSVILLE 47715	CRS	296
SPALDING, WENDELL, L, 820 LINCONWAY WEST MISHAWAKA 46544	GP	256	SPRECHER, JAMES, JOHN J, 900 'I' ST LA PORTE 46350	GP	178
SPANGLER, JESSE, SAML, 2126 SOUTH WEBSTER KOKOMO 46901	GS	126	SPRINGSTUN, GEO, HOBART, OAKTOWN 47561		162
SPARKS, ALAN, LEO, 7456 LIONSHEAD DR INDIANAPOLIS 46260	OTO	134	SPRINGSTUN, WALTER, R, 854 LODGE AVE EVANSVILLE 47714	PD	296
SPARKS, PAUL, WIN, 212 S MAIN ST WINCHESTER 47394	GS	246	SPURGEON, CHARLES, HADDON, 2500 WEST 42ND ST INDIANAPOLIS 46208	N	134
SPEAKS, JOHN, KERN, 400 PUBLIC SQ PAOLI 47454	GP	210	SPURLOCK, FAE, HEDRICK, 1625 WESTERN LAFAYETTE IN 47906	P	286
SPEAS, ROBT, CALVIN, 402 TRIBUNE BLDG TERRE HAUTE 47801	OTO	298	SPUTH, CARL, BROSIUS, 5506 E 16TH ST INDIANAPOLIS 46218	OTO	134
SPECK, CARLSON, RAYMOND, BALL MEM HOSP MUNCIE 47303	R	062	SRI, PRASIT, 30 DOUGLAS HAMMOND 46320	ORS	174
SPELLMEYER, JOHN, CLAIR, REID MEMORIAL HOSP 1401 CHESTER BLVD RICHMOND 47374	R	314	SROKA, STANLEY, JOS, 2942 HIGHWAY AVE HIGHLAND 46322	GP	174

TADLER, HAROLD, E, 41 N SHORTRIDGE RD INDIANAPOLIS 46219	PD	134	STAUFFER, RICHARD, C, 2730 E STATE ST FORT WAYNE 46805	ORS	082
TAFFORD, TOM, MICHAEL, 2828 FAIRFIELD AVE FORT WAYNE 46807	OBG	082	STAUNTON, HENRY, A, 3016 MISHAWAKA AVE SOUTH BEND 46615	GP	258
TAFFORD, WM, CLAYTON, BOX 97 PLAINFIELD 46168	IM	118	STAYTON, CHESTER, A, 1500 ALBANY ST STE 906 BEECH GROVE 46107	R	134
TAKEM, BRIAN, EDWARD, 2600 GREENBUSH ST LAFAYETTE 47904	R	286	STECY, PETER, 1923 CLARK AVE WHITING 46394	GP	174
TALLINGS, HUGH, ALCYSIUS, P O BOX 5525 EVANSVILLE 47715	OBG	296	STEELE, EVERETT, B, 318 S EAST ST CROWN POINT 46307	GP	174
TALLMAN, CARL, F, 409 E WAYNE ST KENDALLVILLE 46755	GP	206	STEELE, HUGH, HENDERSON, 2600 GREENBUSH LAFAYETTE 47902	GE	286
TALTER, GAYLORD, W, NORTH WEBSTER 46555		326	STEELE, LOWELL, R, 2712 BLUFF COURT BLOOMINGTON 47401	CRS	202
TAMPER, JOS, HERBERT, 619 STATE ROAD 67 W ANDERSON 46013	AN	186	STEELE, RONALD, EDWARD, 9251 N DELAWARE INDIANAPOLIS 46240	U	134
TAMPER, ROBT, J, 1415 RAIBLE AVE ANDERSON 46011	GP	186	STEEN, LOWELL, HARRISON, 2450 169TH ST HAMMOND 46323	IM	174
TAMPS, THOS, EDWARD, 3700 BELLEMEADE EVANSVILLE 47715	IM	296	STEFFEN, JULIUS, T, 443 N WABASH ST WABASH 46992	GP	302
TANGLE, WM, J, BLOOMINGTON HOSP BLOOMINGTON 47401	R	214	STEFFY, RALPH, MAURICE, 504 W ARCH ST PORTLAND 47371	GP	146
STANLEY, JOHN, ROBT, 1111 W JACKSON ST MUNCIE 47305	OBG	062	STEGER, BYRON, L, 5241 MAROTT COURT INDIANAPOLIS 46226	OS	134
STANLEY, ROBT, GOULD, 3610 BROOKLYN AVE FORT WAYNE 46807	FP	082	STEICHEN, JAMES, BAPTISTE, 8402 HARCOURT RD STE 217 INDIANAPOLIS 46260	ORS	134
STANSBURY, WM, EDWARD, 5601 E 21ST ST INDIANAPOLIS 46218	GP	134	STEIGMEYER, DAVID, J, 3124 E STATE ST FORT WAYNE 46805	PD	082
STARK, WILLIAM, A, 1601 FRANKLIN ST MICHIGAN CITY 46360	ORS	178	STEIN, RICHARD, H, 502 AMERICAN BANK BLDG VINCENNES 47591	AN	162
STARKS, WILLIAM, O, 3405 NICHOL AVE ANDERSON 46011	ORS	186	STEINEM, JOS, LINSOTT, 818 GRAND AVE CONNERSVILLE 47331	FP	074
STASICK, MURRAY, 7330-38 INDIANAPOLIS BLVD HAMMOND 46324	GP	174	STEINKELER, STEVEN, M, 8330 NAAB RD INDIANAPOLIS 46260	FP	134
STAUFFER, GEO, E, MOORELAND 47360	GP	122	STEINMETZ, EDWARD, FRANCIS, 8402 HARCOURT RD INDIANAPOLIS 46260	CD	134

STEPHENS, DONALD, E, 1440 E 46TH ST INDIANAPOLIS 46205	GP	134	STEWART, RALPH, WM, P O BOX 979 501 SOUTH SIXTH ST VINCENNES 47591	OPH	162
STEPHENS, JAMES, PICKARD, 215 WARD ST CRAWFORDSVILLE 47933	GP	198	STIBBINS, WARREN, EDWARD, 4111 WHEELING AVE MUNCIE 47304	GP	062
STEPHENS, LOWELL, R, BOX 185 COVINGTON 47932	FP	086	STIER, PAUL, LOUIS, 721 BROADWAY FORT WAYNE 46802	IM	088
STEPHENS, SUSAN, ANN R, 4730 ROYAL OAK LANE CARMEL 46032	GP	062	STILLER, AILEEN, GRIFFIN, 1200 MICHIGAN AVE LA PORTE 46350	OBG	178
STEPLETON, JOHN, DAVID, REID MEM HOSP RICHMOND 47374	PTH	314	STILWELL, BARBARA, M L, 5140 N MERIDIAN ST INDIANAPOLIS 46208		134
STERN, MONA, KAUFMAN, 7535 E HAROLD AVE GARY 46403	GP	174	STILWELL, WM, R, 2607 SOUTH C PL RICHMOND 47374	AN	314
STERNE, JOHN, HOWARD, P O BOX 5166 EVANSVILLE 47715	ORS	296	STIMSON, HARRY, RENNER, 1815 EAST IRELAND ROAD SOUTH BEND 46615	FP	258
STEURY, ERNEST, MILLARD, BOX 3039 BUMET SOTIK KENYA EAST AFRICA 60263	GP	134	STINE, MARSHALL, E, 424 W SOUTH ST BREMEN 46506	GP	190
STEUSSY, CALVIN, N, 601 HOSIER DR NEW CASTLE 47362	PTH	122	STINSON, WM, MEFFORD, 2101 JACKSON ST ANDERSON 46014	GP	186
STEVENS, ADAM, CHAS, 203 W DIAMOND ST KENDALLVILLE 46755	R	318	STOELTING, J, LEWIS, 1724 N 7TH TERRE HAUTE 47804	OBG	298
STEVENS, EDWIN, W, 7905 CALUMET AVE MUNSTER 46321	IM	174	STOELTING, ROBT, KENNETH, 11424 DONA DR CARMEL 46032	AN	134
STEVENSON, JERRY, L, 2017 MELODY LN ANDERSON 46012	PTH	186	STOELTING, VERGIL, K, 4706 LAUEL CR INDIANAPOLIS 46226	AN	134
STEWART, PAUL, WAYNE, 12110 GRANT ST CROWN POINT 46307	GP	174	STOGDILL, WM, J, 520 N COQUILLARD SOUTH BEND 46617	GP	258
STEWART, J, FRANK W, P O BOX 513 VINCENNES 47591	PUD	162	STOGSDILL, WILLIS, W, 505 B WEST HUNTERS DRIVE CARMEL 46032	AN	134
STEWART, JOHN, CHAS, OAKLAWN COMM MENTAL HTH CENTER 2600 OAKLAWN AVE ELKHART 46514	P	070	STOLLER, LEON, JUSTUS, 2 OAK MEADOW PLACE R#BROWNING EVANSVILLE 47711	OBG	296
STEWART, L, RAY, 611 HARRIET ST EVANSVILLE 47714	R	296	STOLTZ, ROBT, M, 1406 LA PORTE AVE VALPARAISO 46383	GP	230
STEWART, PAUL, NORFLEET, 740 EAST 52ND ST INDIANAPOLIS 46205	CHP	134	STOLZ, THOS, J, BOX 398 OTTERBEIN 47970	GP	286
			STONE, ALVIN, T, 6202 N COLLEGE AVE INDIANAPOLIS 46220	GP	134

STONE, DAVID, FRED, 245 SE STEBBINS TERR PUNTA GORDA FL 33950	OS	134	STRICKLAND, NEIL, RICHARD, 5506 E 16TH ST INDIANAPOLIS 46218	OBG	134
STONE, ROBT, CHAS, 405 S CAVIN ST LIGONIER 46767	GP	206	STRINGER, DRENNON, DURWOOD, 303 S MAIN ST MISHAWAKA 46544	IM	258
STONE, WM, MAURICE, 3266 NGRTH MERIDIAN ST INDIANAPOLIS 46208	OBG	134	STROUD, PAUL, E, 8058 WITHERINGTON ROAD INDIANAPOLIS 46268	OBG	134
TOOKEY, RICHARD, DON, 295 S WISCONSIN ST HOBART 46342	GP	174	STRUEH, PAUL, EDWARD, 220 S E 7TH ST EVANSVILLE 47713	OTO	296
TORER, WM, R, 3266 N MERIDIAN APT 701 INDIANAPOLIS 46208	CD	134	STRYCKER, DEAN, LA MAR, 2495 REDFIELD ST NILES MI 49120	AN	258
TORREY, D, EDMUND, 1010 E 86TH BLDG 1050 INDIANAPOLIS 46240	IM	134	STUCKY, ELSWORTH, KEENE, 1349 MADISON AVE INDIANAPOLIS 46225	GP	134
TOUDER, ALBERT, EDWIN, RR 4 DOCTORS PARK TIPTON 46072	GS	134	STUCKY, JERRY, LUCAS, 5110 N CLINTON FORT WAYNE 46825	FP	082
TOUT, HARRY, T, 1201 OAK ST FRANKFORT 46041	GP	042	STUDEBAKER, LLOYD, R, 300 N TOWNLINE RD LAGRANGE 46761	GP	170
TOVER, MERVIN, C, 7905 CALUMET AVE MUNSTER 46321	PD	174	STUMP, LOYD, K, 5626 EAST 16TH ST SUITE 21 INDIANAPOLIS 46218	IM	134
STRATIGOS, JOS, SPYRIDON, 527 N LAFAYETTE BLVD SOUTH BEND 46601	PM	258	STUMP, THOS, ALBERT, 4486 S MERIDIAN ST INDIANAPOLIS 46217	PTH	134
STRAYER, JOS, WM, 300 VALLEY ST NO 405 LAFAYETTE 47905	PUD	286	STUMPF, EDWIN, E, 610 PROFESSIONAL PARK DR NEW HAVEN 46774	GP	082
STRECKER, WM, LOUIS, 88 ALLENDALE TERRE HAUTE 47802	AN	298	STUNTZ, EDGAR, CHEADLE, 2500 FERRY ST SUITE 200 LAFAYETTE 47904	P	286
STREEPEY, JEFFERSON, I, 1919 STATE ST SUITE 205 NEW ALBANY 47150	GP	078	STURDEVANT, FRANK, MOXLEY, 1101 EAST GLENDALE BLVD VALPARAISO 46383	OBG	230
STREETER, RALPH, T, 3131 E 38TH ST INDIANAPOLIS 46218	OBG	134	STURGIS, DONALD, GRIFFES, 117 S INDIANA AVE SELLERSBURG 47172	FP	034
STREHLER, DON, ALLEN, 303 S MAIN ST BLUFFTON 46714	PD	318	SUELZER, JOHN, G, 3266 NORTH MERIDIAN ST NO 508 INDIANAPOLIS 46208	ORS	134
STRIBLING, JAMES, LESLIE, 2030 DOCTORS PARK COLUMBUS 47201	GYN	014	SUESS, ROBT, EDWIN, 7504 MORNINGSIDE DR INDIANAPOLIS 46240	IM	134
STRICKER, PAUL, JAMES, 701 FAIR OAKS DR NEW CASTLE 47362	GP	122	SUGARMAN, DONALD, RAYMOND, 2200 LAKE AVE SUITE 150 FORT WAYNE 46805	R	082
STRICKLAND, JAMES, W, 8402 HARCOURT RD SUITE 217 INDIANAPOLIS 46260	ORS	134	SULIT, SEVERINO, TORRES, 603 E NORTH HARTFORD CITY 47348	GS	062

SULLIVAN, JAMES, JERRY, 7824 SHADY HILLS DR INDIANAPOLIS 46278	PTH	134	SZYNAL, JOHN, S, 2811 E 46TH ST INDIANAPOLIS 46205	GS	134
SULLIVAN, ROBT, E, 3030 LAKE AVE FORT WAYNE 46805	GS	082	TABION, NAPOLEON, C, 513 RIDGE ROAD MUNSTER 46321	U	174
SUMMERLIN, JACK, D, 3351 N MERIDIAN INDIANAPOLIS 46208	OTO	134	TACKER, WILLIS, ARNOLD, 2901 WILSHIRE AVE WEST LAFAYETTE 47906	GP	286
SUN, CHEN, TUNG, HEBRON CLINIC HEBRON 46341	GS	230	TADATADA, VICTORIANO, JOSE, 103 E MARKET ST SALEM 47167	FP	310
SURIAN, MICHAEL, ANDREW, 411 WEST FIRST ST BLOOMINGTON 47401	U	214	TALBERT, PIERRE, CARL, 303 S MAIN ST BLUFFTON 46714	GS	318
SURRATT, MARY, A NORRIS, 6160 N MERIDIAN INDIANAPOLIS 46208	OPH	134	TALBOTT, DAN, EUGENE, R R 3 BOX 250A ZIONSVILLE 46077	OBG	134
SUWANWILAI, CHAROEN, ST CATHERINE HOSP 4321 FIR ST EAST CHICAGO 46312	PTH	174	TALLEY, TERRY, WAYNE, 611 HARRIET ST STE 403 EVANSVILLE 47710	OPH	296
SUZUKI, TSUTOMU, TOM, 505 WASHINGTON ST COVINGTON 47932	GP	086	TAN, EUGENIO, N, R R 13 BOX 420 ROCKY CREEK E BEDFORD 47421	AN	182
SWAIM, J, FRANKLIN, P O BOX 185 ANDERSON ST ROCKVILLE 47872	GP	218	TAN, JUAN, 60 DOUGLAS HAMMOND 46320	EM	174
SWAN, JOHN, RAYMOND, 320 ARDEN DRIVE INDIANAPOLIS 46220	OTO	134	TAN, MANUEL, L, 5800 FAIRFIELD AVE FORT WAYNE 46802	AN	082
SWANK, LUCRETIA, RICHISON, 1600 E JACKSON BLVD ELKHART 46514	AN	070	TANNER, MARTHA, H, 619 W FIRST ST BLOOMINGTON 47401	IM	214
SWEARINGEN, ALFRED, G, 2802 E STATE BLVD FORT WAYNE 46805	R	082	TANRIKULU, ORHAN, 2450 169TH ST HAMMOND 46323	PD	174
SWEENEY, ROBT, MUROL, 115 N SUNNYSIDE AVE SOUTH BEND 46617	PD	258	TAPLEY, DWIGHT, L, 61047 U S HWY 31 SOUTH SOUTH BEND 46614	GP	258
SWIHART, DANNY, DALE, SIMPSON AND SUPERIOR ELKHART 46514	FP	070	TAPNIO, ROGELIO, ORDONEZ, 401 EAST REYNOLDS DR KOKOMO 46901	GE	126
SWIHART, JOHN, JACOB, 882 PINE ST WINNETKA IL 60093	PTH	190	TARRY, KIRBY, BRUCE, 1920 DOCTORS PARK COLUMBUS 47201	U	014
SYMME, ALFRED, T, 1010 E 86TH ST INDIANAPOLIS 46240	IM	134	TATE, A, ELIZABETH GARBEK, 317 SOUTH MAIN ST DUNKIRK 47336	GP	146
SZANTO, PHILIP, A, 1152 HOLLY LANE MUNSTER 46321	PTH	174	TATE, THOS, DALE, 3610 BROOKLYN AVE FORT WAYNE 46809	GP	082
SZUMILAS, PETER, PAUL, 2009 BROWN ST ANDERSON 46014	OBG	186			

AUBE, JACK, I, 803 CHAMBER OF COMMERCE BLDG INDIANAPOLIS 46204	OPH	134	TEN BARGE, DAVID, PAUL, 801 ST MARYS DR SUITE NO 207 EVANSVILLE 47715	D	296
AUBE, ROBT, ROY, 321 WEST 20TH STREET CONNERSVILLE 47331	GS	074	TENNANT, DAVID, LEWIS, 4802 CALUMET FORT WAYNE 46806	CM	082
AUEL, MORTON, EDWARD, 1139 FREDERICH S DR INDIANAPOLIS 46260	CD	134	TERRILL, RICHARD, W, 446 W PONTIAC AVE FORT WAYNE 46807	OPH	082
TAYLOR, CLIFFORD, C, 3720 BRIARWOOD DR E INDIANAPOLIS 46240	R	134	TERRY, LLOYD, SHERMAN, 292 W MARION DANVILLE 46122	GP	118
TAYLOR, DONALD, ROSS, BALL MEM HOSP MUNCIE 47303	R	062	TEST, CHAS, EDWARD, 1559 CONSOLIDATED BLDG INDIANAPOLIS 46204	IM	134
TAYLOR, EVERETT, CHAS, UPLAND 46989	GP	098	TETER, GEO, VINCENT, 1221 E 86TH ST INDIANAPOLIS 46240	PD	134
TAYLOR, FREDERIC, WM, 40 EAST 43RD ST INDIANAPOLIS 46205	GS	134	TETHER, JOS, EDWARD, 3266 N MERIDIAN APT 604 INDIANAPOLIS 46208	IM	134
TAYLOR, HAROLD, FRANK, 9436 N KENWOOD AVENUE INDIANAPOLIS 46260	NM	134	TETRICK, ELBERT, L, NATIONAL STEEL CORP PORTAGE 46368	DM	230
TAYLOR, JAMES, ALVIN, DELCO-REMY GMC ANDERSON 46011	DM	186	THARP, DONALD, W, 3201 W PETTY RD MUNCIE 47304	OPH	062
TAYLOR, JAMES, EDWARD, 1101 EAST GLENDALE BLVD VALPARAISO 46383	GP	230	THARP, JOHN, D, 3111 WEST JACKSON ST MUNCIE 47304	U	062
TAYLOR, JOHN, RICHARD, 105 N MAIN ST PALESTINE IL 62451	GP	282	THATCHER, HUGH, K, 1010 EAST 86TH ST NO 24 INDIANAPOLIS 46240	FP	134
TAYLOR, ROBT, GEO, 605 PROFESSIONAL PARK DR NEW HAVEN 46774	RHU	082	THAYER, BENET, WM, 20 JACKSON ST NORTH VERNON 47265	GP	140
TAYLOR, ROBT, LEONARD, 206 MEADOW DR DANVILLE 46122	GS	118	THEPHASDIN, JIROJ, 5800 BROADWAY MERRILLVILLE 46410	NS	174
TEAGUE, FRANK, W, 1500 ALBANY ST BEECH GROVE IN 46107	ORS	134	THOMAN, REX, LEROY, 7338 N CHESTER INDIANAPOLIS 46240	IM	134
TEAL, DOROTHY, DENZLE, 728 FRANKLIN ST COLUMBUS 47201	GP	014	THOMAS, CHAS, RICHARD, 9009 E SOUTHPORT RD INDIANAPOLIS 46259	OBG	134
TEIXLER, VICTOR, A, 50 E 91ST STREET INDIANAPOLIS 46240	OPH	134	THOMAS, DANL, D, 3290 GRANT ST GARY 46408	CRS	174
TEMPLETON, IAN, SIM, 1130 MEDICAL PL SEYMOUR 47274	GS	138	THOMAS, EDWARD, PAUL, 3450 N ILLINOIS ST INDIANAPOLIS 46208	A	134
TEMPLIN, DAVID, BROWNING, 308 E COMMERCIAL AVE LOWELL 46356	GP	174	THOMAS, FRED, ARVELLE, 5827 BROADWAY INDIANAPOLIS 46220	AN	134

THOMAS, GERALD, JAY, 3290 GRANT ST GARY 46408	GS	174	THORNTON, MAURICE, JOHN, 125 W MARION ST SOUTH BEND 46601	R	251
THOMAS, JOHN, ROBT, 347 W BERRY ST FORT WAYNE 46802	OTO	082	THROOP, FRANK, B, 3266 N MERIDIAN STE 508 INDIANAPOLIS 46208	ORS	134
THOMAS, LOWELL, I, 28 W HAMPTON DR INDIANAPOLIS 46208	OKS	134	THUPVONG, CHAWTIPYA, D, 6401 ARTHUR STREET MERRILLVILLE 46410	AN	174
THOMAS, MICHAEL, HOLMES, 330 LEXINGTON AVE ELKHART 46514	U	070	THUPVONG, KOSIN, 7895 BROADWAY MERRILLVILLE 46410	CDS	174
THOMAS, MORRIS, E, 1500 ALBANY ST NO 912 BEECH GROVE 46107	IM	134	THURSTON, FLOYD, EDWARD, 8045 SCARBOROUGH CT INDIANAPOLIS 46256	R	266
THOMAS, W, CLAYTON, 109 JOHN ST NOBLESVILLE 46060	GP	106	THURSTON, JOHN, BRADLEY, 5836 GATEWAY DR INDIANAPOLIS 46254	PS	134
THOMPSON, BURTIS, J, MARION GEN HOSP MARION 46952	PTH	098	TICSAY, FENVENIDO, V, 1225 E COOL SPRINGS MICHIGAN CITY 46360	U	178
THOMPSON, CLAUDE, N, WAYNETOWN 47990	GP	198	TIELKER, RICHARD, ELMER, 3217 LAKE AVE FORT WAYNE 46805	GP	082
THOMPSON, JOHN, M, 209 SHERLAND BLDG SOUTH BEND 46601	OPH	258	TIERNEY, WM, JOS, 1431 N MADISON AVE ANDERSON 46016	GS	186
THOMPSON, JOS, FRANCIS, 1106 W MICHIGAN ST INDIANAPOLIS 46202	OBG	134	TIFFANY, JOS, CALVIN, 6111 HARRISON ST MERRILLVILLE 46410	GS	174
THOMPSON, LARRY, GENE, 604 NORTH MICHIGAN ST SOUTH BEND 46601	AN	258	TIGNOR, STERLING, PRESTON, 401 E REYNOLDS DR KOKOMO 46901	GS	126
THOMPSON, PAUL, DE VIZE, 625 BOARD OF TRADE BLDG INDIANAPOLIS 46204	OPH	134	TILEY, GEO, ARTHUR, 41 N MADISON AVE GREENWOOD 46142	GP	158
THOMPSON, SAML, RICHARD, 625 W BERRY ST FORT WAYNE 46802	OPH	082	TILKA, EDWARD, CHAS, 7134 CALUMET AVE HAMMOND 46324	GP	174
THOMPSON, W, TURTON, 1403 YOUNGSTOWN DR JEFFERSONVILLE 47130	GS	034	TINDALL, GEO, T, 6555 CHESTER E DR INDIANAPOLIS 46220	GP	134
THOMPSON, WAYNE, H, 5470 E 16TH ST INDIANAPOLIS 46218	GS	134	TINDALL, WM, RUSSELL, 505 S HARRISON ST SHELBYVILLE 46176	GP	266
THOMPSON, WM, R, 111 N MONTICELLO ST WINAMAC 46996	GP	238	TINIO, WILFRIDO, MORA, 2919 RAMBLE RD WEST BLOOMINGTON 47401	AN	214
THONG, SIONG-HOAT, 5800 FAIRFIELD AVE FORT WAYNE 46807	AN	082	TINSLEY, WALTER, B, 8432 W 85TH ST INDIANAPOLIS 46278	AN	134
THORNTON, HAROLD, CLIVE, 301 E 38TH ST INDIANAPOLIS 46205	PTH	134	TIRMAN, WALLACE, S, JEFFERSON MED ARTS BLDG NO 207 SOUTH BEND 46622	R	258

TRUCHELVAM, ROHAN, L M, 2785 NORTH VALHALLA DR MARION 46952	AN	098	TRACHTENBERG, LEE, H, 1646 45TH AVE MUNSTER 46321	OPH	174
ISSERAND, JOHN, B, 3700 BELLEMEADE AVE EVANSVILLE 47715	D	296	TRAINER, TOM, FRANK, 2020 W 86TH ST INDIANAPOLIS 46260	OKS	134
OFAUTE, JOHN, L, 7454 SOMERSET BAY INDIANAPOLIS 46240	ORS	134	TRAN, LAU, LYONS CLINIC LYONS 47443	FP	102
OMLIN, HUGH, MALCOLM, 420 W WASHINGTON ST MUNCIE 47305	IM	062	TRANter, WM, FRANK, 2337 FLORA AVE FORT MYERS FL 33901	OS	290
OMLIN, JERROLD, E, 1220 SPRING ST JEFFERSONVILLE 47130	ORS	034	TREPAGNIER, FRANCIS, BASIL, 8123 KENNEDY HIGHLAND 46322	OPH	174
ONDRA, JOHN, MICHAEL, 8330 NAAB RD INDIANAPOLIS 46260	PS	134	TRIER, HERBERT, PAUL, 2414 FT WAYNE NATL BANK BLDG FORT WAYNE 46802	P	082
OPOLGUS, JAMES, N, 403 N WALNUT ST BLOOMINGTON 47401	OBG	214	TRIMBLE, JOHN, G, 402 SOUTH BERKLEY ROAD KOKOMO 46901	OPH	126
OPOLGUS, JAMES, N, 403 N WALNUT ST BLOOMINGTON 47401	GS	214	TRIPLETT, DOUGLAS, A, PATHOLOGY DEPT 2401 UNIVERSITY AVE MUNCIE 47303	HEM	062
OPPING, MALACHI, COMBS, 3050 POPLAR ST TERRE HAUTE 47803	ORS	298	TRITCH, DAN, LEE, 3610 BROOKLYN FORT WAYNE 46809	FP	082
ORD, JOSE, N, 3266 N MERIDIAN ST INDIANAPOLIS 46208	GE	134	TRUEGER, THOMAS, ALBERT, 912 E LA SALLE SOUTH BEND 46617	HEM	258
ORRES, JOSE, C, 207 SPARKS AVE JEFFERSONVILLE 47130	GS	034	TROTTER, ROGER, COURTNEY, 615 ABBOTT MUNCIE 47304	FP	062
OUSSAINT, LINNE, FENELON, 9124 S BENNETT AVE CHICAGO IL 60617	AN	174	TROUT, CARL, JOS, 800 STATE ST LAFAYETTE 47901	OPH	286
OWANNASUT, VERAPON, 6111 HARRISON ST MERRILLVILLE 46410	OTO	174	TROUT, DAVID, JOS, 2 NORTH 26 LAFAYETTE 47904	OTO	286
OWER, JAMES, H, P O BOX 70 SHELBYVILLE 46176	GP	266	TROY, JACK, MILTON, 2450 169TH ST HAMMOND 46323	PD	174
OWER, THOS, KERMIT, CAMPBELLSBURG 47108	CD	310	TROYER, DANA, O, 201 E CLINTON ST GOSHEN 46526	OPH	070
OWLES, JEFF, HERMAN, 2513 S CALHOUN FORT WAYNE 46806	GS	082	TROYER, MARLIN, L, 328 N MICHIGAN SOUTH BEND 46601	OKS	258
OWNLEY, NORMAND, THOS, 3266 N MERIDIAN INDIANAPOLIS 46208	AN	134	TRUDGEN, SPENCER, FOLLIOTT, 2020 WEST 86TH STREET INDIANAPOLIS 46260	OBG	134
TOYAMA, TSUYOSHI, 713 THORNWOOD DR SOUTH HOLLAND IL 60473	AN	174	TRUSLER, HAROLD, MARSHALL, 1144 CONSOLIDATED BLDG INDIANAPOLIS 46204	PS	134

TSAI,SAN,HUA, 5490 BROADWAY SUITE 112 MERRILLVILLE 46410	OBG	174	TWENTY,JOHN,DOUGLAS, 1440 EAST 46TH ST INDIANAPOLIS 46205	GP	134
TUASON,LEONORIO,BERSAMIN, SUNNYSIDE DR BOX 22 MARTINSVILLE 46151	GS	202	TYNDALL,JOHN,PHILLIP, 3124 E STATE ST FORT WAYNE 46805	OBG	082
TUASON,RICARDO,MAURICIO, 926 WEST MAIN ST MUNCIE 47305	GS	062	TYNER,HARLAN,HOWARD, 3663 N DELAWARE INDIANAPOLIS 46205	OPH	134
TUBERGEN,LAVERNE,B, 1100 W MICHIGAN INDIANAPOLIS 46202	OTO	134	TYRRELL,JOS,J, 800 STATE LINE ST CALUMET CITY IL 60409	GS	174
TUCHMAN,JOS,H, 2040 E 46TH ST INDIANAPOLIS 46205	GP	134	TYRRELL,THOS,CARROLL, 800 STATE LINE ST CALUMET CITY IL 60409	GS	174
TUCKER,WARREN,SAML, 3530 SOUTH KEYSTONE AVE #200 INDIANAPOLIS 46227	PUD	134	U UFKES,HERBERT, 108 STAT ST NORTH JUDSON 46366	GP	274
TUFEKCIOGLU,ERDOGAN, 815 LAPORTE AVE VALPARAISO 46383	R	230	ULGADO,EDMUNDO,SILVANO, 1917 GRAND AVE CONNERSVILLE 47331	GP	074
TUHOLSKI,JAMES,MARTIN, 2404 PENNSYLVANIA ST EVANSVILLE 47721	PD	296	ULLOM,RALPH,B, 2020 W 86TH ST STE 201 INDIANAPOLIS 46260	IM	134
TUMULURI,V,S, 1944 N CAPITOL INDIANAPOLIS 46202	HS	134	ULREY,ROBT,PAUL, 130 E MILL RD EVANSVILLE 47711	AN	296
TUNNELL,HARRY,DANL, P O BOX 5404 FORT WAYNE 46805	GS	082	UMPHREY,JAMES,E, 303 S MAIN ST BLUFFTON 46714	END	318
TURGI,ROBT,W, 6111 HARRISON ST MERRILLVILLE 46410	OTO	174	UNDERHILL,GARY,EUGENE, 421 CHESTNUT ST EVANSVILLE 47713	PD	296
TURNER,ANNA,LUCINDA GOSS, BOX 313 MADISON 47250	AN	150	UNDERWOOD,GEO,MAUZY, JEFFERSON SQUARE LAFAYETTE 47905	GP	286
TURNER,JOHN,PATRICK, 115 E WASHINGTON ST GOSHEN 46526	GP	070	UNGEMACH,WILLC,FREDERICK, 3009 FAIRFIELD FORT WAYNE 46807	IM	082
TURNER,MAURICE,A, 315 NORTH HOME AVE MARTINSVILLE 46151	GP	202	UNNI,RAMAKRISHNAN,P, TWIN TOWERS-SUITE 525 MERRILLVILLE 46410	U	174
TURRELL,EUGENE,SNOW, 600 N ALABAMA #1602 INDIANAPOLIS 46204	P	134	UNZICKER,ROGER,GENE, 103 BROWN ST MIDDLEBURY 46540	FP	070
TUSHAN,FAYEZ,S, 1213 N ARLINGTON AVE INDIANAPOLIS 46219	IM	134	URBA,VYTAUTAS,VICTOR, 7905 CALUMET MUNSTER 46321	P	174
TUTUNJI,NERMIN,DJAMIL, 919 EAST JEFFERSON BLVD SOUTH BEND 46622	CDS	258	URBANSKI,WALTER,PATRICK, 2513 HIGHWAY AVE HIGHLAND 46322	OBG	174
TWEEDALL,DANL,CODY, 715 1ST AVE STE 10 EVANSVILLE 47710	D	296			

JRGENA, REGINO, B, 5857 N 500 W RR 1 MARION 46952	AN	098	VAN METER, C, POWELL, 5470 E 16TH ST INDIANAPOLIS 46218	FP	134
JRRUTI, ARNOLDO, HORACIO, 620 J M S BLDG SOUTH BEND 46601	P	258	VAN NESS, WM, CHAS, 212 SOUTH MAIN ST SUMMITVILLE 46070	GP	186
			VAN NESS, WM, CHAS, NO 11 FAIRWAY DR ALEXANDRIA 46001		186
	V				
YAKKUR, GEO, JURI, 211 NORTH EDDY ST SOUTH BEND 46617	N	258	VAN SCOYC, JON, DARA, 110 LAKEVIEW DR NOBLESVILLE 46060	FP	106
YALENA, DOMINADOR, V, 1206 N PETTY RD MUNCIE 47304	AN	122	VAN TASSEL, CHAS, J, 8402 HARCOURT ROAD INDIANAPOLIS 46260	U	134
YALENCIA, MONICO, M, 2606 CENTRAL CENTER GARY 46405	ABS	174	VAN VACTOR, HELEN, DARE, 1815 N CAPITOL STE 512 INDIANAPOLIS 46202	IM	134
YALENZUELA, DIEGO, CASTRO, 305 E MAIN ST VEVAY 47043	GP	156	VAN WIFNEN, JOHN, 60 W MORGAN ST MARTINSVILLE 46151	GP	202
YALENZUELA, ROBERTO, D, 5490 BROADWAY MERRILLVILLE 46410	GP	174	VANDER WESTHAYSEN, PETER, 7550 HOHMAN AVE MUNSTER 46321	NS	174
YALENZUELA, SOFIA, SALOMON, 5490 BROADWAY MERRILLVILLE 46410	PD	174	VANDIVIER, JAMES, M, 8402 HARCOURT RD STE 309 INDIANAPOLIS 46260	IM	134
YAN BUSKIRK, EDMUND, L, 2600 GREENBUSH LAFAYETTE 47902	OPH	286	VANDIVIER, ROBT, M, RR 3 BOX 1446 FRANKLIN 46131	IM	134
YAN CAMPEN, WARREN, MILTON, 8402 HARCOURT ROAD SUITE 701 INDIANAPOLIS 46260	AN	134	VAUGHN, WALTER, R, 615 DUBOIS ST VINCENNES 47591	U	162
YAN DENBARK, HOWARD, M, 313 C SOUTH BERKLEY RD KOKOMO 46901	OBG	126	VEACH, LESTER, WARDLAN, BAINBRIDGE 46105	GP	242
YAN FLEET, JOSEPHINE, 1330 W MICHIGAN ST INDIANAPOLIS 46206	PH	134	VEACH, RICHARD, LESTER, BAINBRIDGE 46105	GP	242
YAN FLEIT, WM, EDMUND, 919 E JEFFERSON 407 SOUTH BEND 46622	CDS	258	VEACH, WM, L, 1235 OHIO ST TERRE HAUTE 47807	U	298
YAN HOEK, ROBT, WISHARD MEMORIAL HOSPITAL INDIANAPOLIS 46202	OS	134	VEATCH, RONALD, I, 3202 N MERIDIAN ST INDIANAPOLIS 46208	R	134
YAN HOVE, EUGENE, DENNIS, 7816 WINDCOMBE BLVD INDIANAPOLIS 46240	NM	134	VELASQUEZ, ARMANDO, U S STEEL 215 BROADWAY GARY 46402	GS	174
YAN KIRK, JOHN, ROBT, 2496 SYCAMORE LANE WEST LAFAYETTE 47906	GP	286	VELUZ, MARIO, ISAAC, P O BOX 882 GARY 46402	P	174
YAN KIRK, PAUL, PHILLIP, 105 WEST WASHINGTON ST MONTICELLO 47960	OS	322	VENABLES, ALBERT, J, 420 RUNNYMEADE EVANSVILLE 47714	PTH	296

VERDE, HORACIO, V, 1742 BEACHVIEW COURT CROWN POINT 46307	P	230	VOGEL, JOHN, L, 215 E VAN BUREN COLUMBIA CITY 46725	IM	326
VERGARA, ABELARDO, F, 2943 42ND ST HIGHLAND 46322	DM	174	VOGEL, LAWRENCE, JOHN, 722 MAIN ST MOUNT VERNON 47620	GP	234
VERMILYA, ROBT, WELSH, 1001 LIFE BLDG LAFAYETTE 47901	AN	286	VOGEL, LLOYD, ALBERT, 13433 LIBERTY MILLS ROAD FORT WAYNE 46804	EM	082
VESEY, WM, JOS, 711 RIVER DR MARION 46952	GTO	098	VOLAN, GEORGE, J, 7895 BROADWAY MERRILLVILLE 46410	GS	174
VIBUL, SANTI, 801 ST MARYS DRIVE EVANSVILLE 47715	TS	296	VOLLRATH, VICTOR, JOHN, 5202 N ILLINOIS ST INDIANAPOLIS 46208	GP	134
VIEGAS, BRENDA, P, 4097 EASY ST GREENWOOD 46142	PL	158	VON ASCH, GEO, FREDERICK, 2030 MICHIGAN AVE LA PORTE 46350	GP	176
VIEGAS, OSCAR, J, 4097 EASY STREET GREENWOOD 46142	AN	134	VON DER HAAR, GERARD, A, 1640 N RITTER ST INDIANAPOLIS 46218	GP	134
VIEIRA, JOSE, THOS, RD 2 SUNSET LAKE COATESVILLE 46121	GP	242	VON DER LIETH, WM, P CAREW, BOX 703 VINCENNES 47591	GS	162
VILLA, FLORENCIO, CASTILLO, 223 W OAK ST UNION CITY 47390	GS	246	VONDER HAAR, THOS, E, 515 READ ST EVANSVILLE 47710	IM	296
VILLANUEVA, ONOFRE, Q, 1812 BENHAM FORT WAYNE 46808	PL	082	VOORHIES, MC, KINLEY, 1940 MASSACHUSETTS GARY 46407	GP	174
VINCENT, JOHN, PAUL, 3700-179TH ST HAMMOND 46323	ORS	174	VORE, ROBT, E, 5350 MARMON CIRCLE INDIANAPOLIS 46226	AN	134
VINCENT, WM, ADAM, 421 CHESTNUT ST EVANSVILLE 47713	IM	296	VORMOHR, JOS, FRANK, 604 W ARCH ST PORTLAND 47371	GP	146
VINLUAN, TEOFILO, S, 131 N WASHINGTON ST MARION 46952	IM	098	VOSS, GERT, 420 W WASHINGTON ST MUNCIE 47305	OBG	062
VIRAY, VICTORIANO, G, 804 N DRIVE CRAWFORDSVILLE 47933	GS	198	VOYLES, HARRY, ELWOOD, 425 BEHARRELL AVE NEW ALBANY 47150	GP	078
VIVIAN, DONALD, E, R R 4 NEW CASTLE 47362	DR	122			
VIX, VERNON, A, INDIANA UNIV MED CTR RADIOLOGY DEPT INDIANAPOLIS 46202	K	134	WACHOB, TOM, W, 3520 S LA FOUNTAIN KOKOMO 46901	OBG	126
VIZCARRA, RUBEN, FABIAN, 212 FIFTH ST LOGANSPOUT 46947	GP	030	WADDELL, J, RONALD, 611 HARRIET ST-STE 501 EVANSVILLE 47710	GS	296
VLASKAMP, ELAINE, MARIE, 500 W CHARLES ST MUNCIE 47305	GP	062	WADE, REYNOLDS, WAYNE, 4105 DALEWOOD DR FORT WAYNE 46805	FP	082

ADLF, ROBERT, HAROLD, 7905 CALUMET AVE MUNSTER 46321	PD	174	WAKIM, KHALIL, GEORGES, 807 SOUTH FIFTH TERRE HAUTE 47807	OS	298
AECHTER, FRANK, EDWARD, 5208 STONEHEDGE DR EVANSVILLE 47715	OBG	296	WAKSMAN, ALBERTO, 303 S MAIN ST BLUFFTON 46714	PTH	318
AGNER, ARTHUR, L, 115 E 9TH ST JASPER 47546	GP	066	WALDO, GUY, HAROLD, 2900 W 16TH BEDFORD 47421	IM	182
AGNER, LINDLEY, HEATH, 2424 FERRY ST LAFAYETTE 47904	IM	286	WALDO, JEANE, THAYER, 420 W 64TH ST INDIANAPOLIS 46260	OS	134
AGNER, RICHARD, W, 1355 GUILFORD ST HUNTINGTON 46750	GP	130	WALERKO, FRANK, 919 E JEFFERSON BLVD SOUTH BEND 46622	U	258
AGNER, VIRGINIA, MEADE, 510 COUNTY CLUB RD INDIANAPOLIS 46234	PD	134	WALKER, ADOLPH, PAUL, 8630 LINDEN AVE MUNSTER 46321	AN	174
AGNER, WM, LESLIE, 1655 HAWTHORNE DR PLAINFIELD 46168		118	WALKER, EDWIN, MERCER, 501 N IRONWOOD DR SOUTH BEND 46615	AN	258
AGNER, BILLY, D, RR 2 UNION CITY 47390	GP	246	WALKER, FLOYD, BROWN, 4927 SOUTH LAFAYETTE ST FORT WAYNE 46806	GP	082
AGNER, DON, JARED, BOX 324 BURLINGTON 46915	GP	026	WALKER, G, DALY, 3200 SYCAMORE CT SUITE 1-D COLUMBUS 47201	GS	014
AGNER, GEO, WESLEY, 202 W MAIN ST DELPHI 46923	GP	026	WALKER, JACK, M, 412 WHITE RIVER BLVD MUNCIE 47303	ORS	062
AGNER, J, EDWARD, 2525 SOUTH ST LAFAYETTE 47904	ORS	286	WALKER, ROBT, MURRAY, P O BOX 1149 BLOOMINGTON 47401	EM	214
AGNER, JOHN, ROBT, 215 WEST 19 ANDERSON 46014	U	186	WALKER, THOS, MARTIN, E MAIN ST BROWNSBURG 46112	GP	118
AGNER, MARILYN, L ASHER, BOX 324 BURLINGTON 46915	GP	026	WALLACE, COLLINS, ROBT, 126 TIMBERLANE FORT WAYNE 46825	AN	082
AHLE, WM, MONTGOMERY, 1710 BREWSTER RD INDIANAPOLIS 46260	PTH	134	WALLACE, ELMER, L, 1919 STATE NEW ALBANY 47150	GP	078
AINSCOTT, CLINTON, S, 1303 N ARTINGTON AVE SUITE 10 INDIANAPOLIS 46219	ORS	134	WALLACK, ELIOT, M, 5508 E 16TH ST INDIANAPOLIS 46218	N	134
AISS, ELAINE, HELEN, 8203 SCHREIBER DR MUNSTER 46321	FP	174	WALTER, PAUL, A F, 2404 PENNSYLVANIA AVE EVANSVILLE 47721	OS	296
WAITS, CHESTER, LA VERNE, 49 N 26TH ST LAFAYETTE 47904	GP	286	WALTER, ROBT, FREDERICK, 1514 S KENTUCKY AVE EVANSVILLE 47714	FP	296
WAKEFIELD, DONALD, LEE, 3410 BAYLEAF DR LEXINGTON KY 40502	CD	134	WALTERS, CHAS, EDWARD, 319 S SPRING ST MISHAWAKA 46544	GS	258

WALTERS, JACK, LEON, 95 E OAK ST ZIONSVILLE 46077	GP	158	WARR, ARTHUR, CLIVE, 5050 NORTH CLINTON FORT WAYNE 46825	ORS	081
WALTERS, WM, HAROLD, 3714 FRANKLIN ST MICHIGAN CITY 46360	CRS	178	WARREN, ROBT, JOE, 1434 CHESTER BLVD RICHMOND 47374	PD	314
WALTHALL, GERALD, CHAS, 3530 SOUTH KEYSTONE NO 310 INDIANAPOLIS 46227	OTO	134	WARRICK, FRANCIS, B, 100 N 15TH ST RICHMOND 47374	IM	314
WALTHER, JOS, E, 4266 PENN ST INDIANAPOLIS 46205	IM	134	WARRICK, HOMER, LYLE, R R 1 BOX 320F EDWARDSBURG MI 49112	GP	258
WALTON, FRED, RICHARD, JENNINGS CO HOSP NORTH VERNON 47265	GS	143	WARRINER, JAMES, BURTON, 1012 N EMERSON AVE INDIANAPOLIS 46219	IM	134
WALTON, RICHMOND, L, 1251 KEM ROAD MARION 46952	PD	098	WARVEL, JOHN, HENRY, 1075 W 91ST ST INDIANAPOLIS 46260	IM	134
WALTON, WM, M, 3530 S KEYSTONE #303 INDIANAPOLIS 46227	U	134	WASHINGTON, WILBERT, 2142 N CAPITOL AVE INDIANAPOLIS 46202	OPH	134
WAMBO, JOHN, M, 900 SIM HODGIN PARKWAY RICHMOND 47374	OBG	314	WASS, JUSTIN, LEO, 3401 N RYBOLI APT D INDIANAPOLIS 46222	DR	134
WANG, TIEH, CHUN, 1327 RIDGEWAY MUNSTER 46321	PTH	174	WATERFALL, KIM, W, 3217 LAKE AVE FORT WAYNE 46805	FP	082
WANGELIN, RICHARD, 17 DOUGLAS PLACE TERRE HAUTE 47803	OPH	298	WATKINS, LARRY, EUGENE, 301 EAST MAUMEE ANGOLA 46703		278
WARBINTON, FRED, PHILLIP, 215 WARD ST CRAWFORDSVILLE 47933	GP	196	WATSON, JAMES, RITZ, 3217 LAKE AVE FORT WAYNE 46805	FP	082
WARD, GERALD, FREMONT, 3124 E STATE FORT WAYNE 46805	U	082	WATSON, LEO, GENE, 3433 S LAFOUNTAIN KOKOMO 46901	OPH	126
WARD, JAMES, WESLEY, 301 NORTH OCEAN BLVD APT 506 POMPANO BEACH FL 33062	AN	258	WATSON, STEPHEN, CLAIR, ST VINCENT HOSP INDIANAPOLIS 46260	EM	134
WARE, JOHN, REED, RUSSIAVILLE 46979	GP	126	WATTS, EDWIN, SCULLY, 8235 CALUMET AVE MUNSTER 46321	P	174
WARFIELD, CHESTER, H, 7024 FOREST WOOD DR FORT WAYNE 46805	R	082	WAY, JAMES, ALFRED, 2315 E 3RD BLOOMINGTON 47401	OPH	214
WARN, WM, JOHN, MILAN 47031	GP	250	WAYMIRE, WM, MERLE, 101 WALNUT ST FRANKLIN 46131	R	15
WARNEKE, CHAS, HAGER, 1815 N CAPITOL INDIANAPOLIS 46202	ORS	134	WEATHERS, WM, TRAVIS, ST MARYS HOSPITAL 3700 WASHINGTON AVE EVANSVILLE 47750	PD	29
WARNER, T, MAX, 7704 SINGLETON STREET INDIANAPOLIS 46227	PTH	134	WEAVER, DOROTHY, EMILY, 3839 E KESSLER BLVD INDIANAPOLIS 46220	UM	13

WEAVER, R, WYATT, 1109 W MAUMEE ANGOLA 46703	FP	278	WEISNER, RICHARD, MEREDITH, ROUTE 1 EATON 47338	FP	062
WEBB, HARRY, D, 515 CITIZENS BANK BLDG ANDERSON 46016	GP	180	WEISS, ALBERT, EMIL, 1225 E COOLSPRING MICHIGAN CITY 46360	GP	178
WEBB, MICHAEL, KEITH, 2020 WEST 86TH ST INDIANAPOLIS 46260	OBG	134	WEISS, BRIAN, H, 535 W 35TH ST GARY 46408	GP	174
WEBER, EDGAR, HARTMETZ, 3008 E POWELL EVANSVILLE 47715	DM	296	WEISS, LOUIS, LLOYD, P O BOX 2129 ANDERSON 46011	AN	186
WEBER, EMIL, LEE, R R 8 BOX 90 BROWNING RD EVANSVILLE 47711	NS	296	WEISS, ROBT, M, 207 PROFESSIONAL ARTS BLDG NEW ALBANY 47150	D	078
WEBER, JOS, G S, R R 1 BOX 62 CENTERPOINT 47840	R	298	WEITEMIER, RAYMOND, A, 1434 CHESTER BLVD RICHMOND 47374	PD	314
WEBER, STEVEN, ALLEN, 198 EAST JEFFERSON ST FRANKLIN 46131	GP	158	WEITZEL, POLAND, E, 114 S HART ST PRINCETON 47670	GP	094
WEBSTER, MONICA, MAE, 2206 N ARLINGTON AVE INDIANAPOLIS 46218	IM	134	WELBOFN, MELL, B, 421 CHESTNUT ST EVANSVILLE 47713	GS	296
WEBSTER, PAUL, L, 527 PARK RIDGE WEST LAFAYETTE 47906	DR	286	WELBORN, MELL, BURRESS, 421 CHESTNUT ST EVANSVILLE 47713	IS	296
WEBSTER, ROBT, KENTON, 25 N BEECH ST BRAZIL 47834	GP	038	WELDY, BRYCE, P, 227 W FRANKLIN ST HARTFORD CITY 47348	OTU	062
WEDDLE, CHAS, O, 360 PLAZA DRIVE COLUMBUS 47201	GS	014	WELLER, RALPH, DEAN, R R 1 BOX 189A ROSSVILLE 46065	GP	286
WEHLAGE, DAVID, FRANCIS, 634 N LAFAYETTE BLVD SOUTH BEND 46601	P	258	WELLER, WENDELL, A, 153 PATHWAY LANE WEST LAFAYETTE 47906	OTO	286
WEINBAUM, JACK, G, BOX 1468 TERRE HAUTE 47808	PTH	298	WELLMAN, HENRY, NELSON, LONG HOSP ROOM 167B INDIANAPOLIS 46202	NM	134
WEINLAND, GEO, CHITTY, R R 9 HARRISON LAKES BOX 378 COLUMBUS 47201	P	014	WELLS, BARBARA, D, 206 FAIRVIEW AVE SPENCER 47460		214
WEIR, GEO, RUSSELL, 2401 UNIVERSITY MUNCIE 47303	PTH	062	WELLS, WM, RUSSELL, 510 N MAIN ST PRINCETON 47670	GP	094
WEIR, ROSEMARY, E KOELLING, 735 REDDING ROAD SEYMOUR 47274	GP	062	WENINGER, DONALD, LEE, P O BOX 485 MICHIGAN CITY 46360	AN	178
WEISENBERGER, BROCKTON, L, 3640 WOODSIDE DR COLUMBUS 47201	DM	014	WENZLER, PAUL, JORDAN, 3901 E 3RD ST BLOOMINGTON 47401	GP	214
WEISKOPF, HENRY, S, 7863 BROADWAY NO 128 MERRILLVILLE 46410	OPH	174	WERTENBERGER, MORRIS, D, 779 GREENMOUNT PIKE RICHMOND 47374	R	314

WESEMAN, MERRILL, MAX, 251 E JEFFERSON ST FRANKLIN 46131	GP	158	WHITE, JOHN, PHILIP, 115 S LINCOLN BLOOMINGTON 47401	OTO	21
WEST, JOS, L, 355 WEST 62ND ST INDIANAPOLIS 46260	GP	134	WHITE, THOS, ROGER, 431 KINGS VALLEY RD EVANSVILLE 47711	CD	29
WEST, ROGER, FRANK, 221 S 6TH ST TERRE HAUTE 47801	PD	298	WHITLOCK, MERLE, E, 2118 LINDEN AVE MISHAWAKA 46544	GS	25
WESTERFIELD, GORDON, LEE, 401 EAST REYNOLDS DR KOKOMO 46901	GP	126	WIATT, LEONARD, H, 2716 W FAIROAKS NEW CASTLE 47362	EM	12
WESTFALL, B, KEMPER, 1251 WEST 86TH ST INDIANAPOLIS 46260	DM	134	WICK, ALFRED, ALBERT, 2120 CAREW ST FORT WAYNE 46805	OPH	08
WEYBRIGHT, WM, LEE, 103 BROWN MIDDLEBURY 46540	GP	070	WICKSTROM, OTTO, W, 2360 N NATIONAL RD COLUMBUS 47201	ORS	01
WHEELER, BARTH, EDMONSON, MEDICAL ARTS BLDG 1255 ENGLE ST HUNTINGTON 46750	GP	130	WIDDIFIELD, GARTH, EUGENE, 532 TURTLE CREEK DR N INDIANAPOLIS 46227	GP	13
WHEELER, BYRON, CLIFFORD, 400 8TH AVE TERRE HAUTE 47804	IM	298	WIERZALIS, EDWARD, F, 2017 SHERMAN ST FORT WAYNE 46808	GP	08
WHEELER, DAVID, E, 1500 N RITTER ST INDIANAPOLIS 46219	R	134	WIETHOFF, CLIFFORD, A, 1131 MEDICAL PL C-9 SEYMOUR 47274	GS	13
WHEELER, EDWARD, CORNELIUS, 3500 N LAFAYETTE RD INDIANAPOLIS 46222	R	134	WIETHOFF, RICHARD, ALLEN, 1131 MEDICAL PL SEYMOUR 47274	GS	13
WHITAKER, JACK, DAWSON, COMMUNITY HOSPITAL 1515 NORTH MADISON AVE ANDERSON 46012	PTH	186	WIGUTOW, MARCOS, 500 WEST LINCOLN HIGHWAY MERRILLVILLE 46410	P	17
WHITCOMB, ROGER, F, 120 W JACKSON ST SHELBYVILLE 46176	GP	266	WILAND, OLIN, K, REID MEM HOSP RICHMOND 47374	PTH	31
WHITE, CHAS, FREDRICK, 5806 HOOVER RD INDIANAPOLIS 46208	PM	134	WILDER, GORDON, BOTKIN, 1337 N NURSERY RD ANDERSON 46012	IM	18
WHITE, DONALD, GEO, 1815 E IRELAND RD SOUTH BEND 46614	FP	258	WILHELM, AGATHA, M, 1032 E WAYNE ST SOUTH BEND 46617	IM	25
WHITE, DONALD, J, 3524 N MERIDIAN INDIANAPOLIS 46208	A	134	WILHELM, GUIDO, PAUL, 1007 N 16TH ST BOX 229 NEW CASTLE 47362	OBG	12
WHITE, DOUGLAS, H, 3524 N MERIDIAN INDIANAPOLIS 46208	IM	134	WILHELMUS, C, KENNETH, 1100 LINCOLN EVANSVILLE 47714	OM	29
WHITE, HARVEY, E, 202 S MAIN ST FARMLAND 47340	GP	246	WILHELMUS, GILBERT, M, 1028 WASHINGTON AVE EVANSVILLE 47714	GP	29
WHITE, JOHN, B, 5626 EAST 16TH ST NO 13 INDIANAPOLIS 46218	ORS	134	WILKENS, IRVIN, WM, 4820 E PLEASANT RUN PKWY N DR INDIANAPOLIS 46201	IM	13

ILKINSON, ROGER, LEWIS, 2009 BROWN ST ANDERSON 46014	GP	186	WILLIS, CHAS, FLEMING, 1100 S BEDFORD AVE EVANSVILLE 47713	GP	296
ILLHITE, LARRY, GALE, 4232 RIVERSIDE DR COLUMBUS 47201	AN	014	WILLIS, ROBT, L, 2828 FAIRFIELD AVE FORT WAYNE 46807	R	082
ILLIAMS, A, BERNIECE M, 6632 QUAIL RIDGE LANE FORT WAYNE 46804	GP	082	WILLISON, GEO, WYMAN, 3700 BELLEMEADE AVE EVANSVILLE 47715	IM	296
ILLIAMS, ALEXANDER, S, 436 W 25TH AVE PO BOX 119 GARY 46401	GP	174	WILLMAN, JOE, IRVIN, RR 1 GASTON 47342	PTH	062
ILLIAMS, EARL, KENNETH, TWO CHASE PARK LOGANSPOUT 46947	R	030	WILLNER, ALAN, 630 EASTERN BLVD CLARKSVILLE 47130	FP	034
ILLIAMS, EDWIN, DANL, 628 E 21ST AVE GARY 46407	GP	174	WILLS, MAX, B, 347 W 7TH ST AUBURN 46706	GP	058
ILLIAMS, EVERETT, W, 1815 PARK VALLY DR COLUMBUS 47201	GP	014	WILSON, DAVID, 615 WILLOW EVANSVILLE 47710	AN	296
ILLIAMS, FRANCIS, M, 1012 PARK ROAD ANDERSON 46011	IM	186	WILSON, DONALD, LEON, 4315 GRAYSON DRIVE INDIANAPOLIS 46208	OPH	134
ILLIAMS, GARY, CHAS, 5941 EAST 30TH ST INDIANAPOLIS 46218	IM	134	WILSON, DOUGLAS, JAMES, 303 S MAIN ST MISHAWAKA 46544	OBG	258
ILLIAMS, HAROLD, WARREN, 6000 E 46TH ST INDIANAPOLIS 46226	GP	134	WILSON, FRED, LEE, 1501 S 3D ST TERRE HAUTE 47802	CD	298
ILLIAMS, HOWARD, S, 3824 NORTH DELAWARE ST INDIANAPOLIS 46205	GER	134	WILSON, FRED, MADISON, R R 2 BOX 296 CARMEL 46032	OPH	134
ILLIAMS, JACK, OWEN, 421 CHESTNUT ST EVANSVILLE 47713	IM	296	WILSON, FRED, MONROE, 2745 LAKEWOOD DR N INDIANAPOLIS 46280	OPH	134
ILLIAMS, JAMES, 711 W KESSLER BLVD INDIANAPOLIS 46208	U	134	WILSON, JAMES, M, 919 E JEFFERSON BLVD SOUTH BEND 46622	GS	256
ILLIAMS, LARRY, V, 2066 RIDGEWOOD LANE MADISON 47250	IM	150	WILSON, JOHN, SMITH, 122 N MAIN ST COLUMBIA CITY 46725	FP	326
ILLIAMS, PAUL, ALLAN, 1103 E GRACE ST RENSSELAER 47978	FP	142	WILSON, NED, ARLAN, 317 N WESTERN MARION 46952	PD	098
ILLIAMS, PAUL, DRAKE, 35 MERIDIAN LANE INDIANAPOLIS 46220	P	134	WILSON, NORMAN, KEITH, 3421 S LAFOUNTAIN ST KOKOMO 46901	GP	126
ILLIAMS, ROBT, D, 2009 BROWN ST ANDERSON 46014	GP	186	WILSON, OLIVER, R, BOX 525 MORGANTOWN 46160	GP	202
ILLIAMSON, ROBERT, T, 2600 GREENBUSH ST LAFAYETTE 47902	OPH	286	WILSON, ORLEY, EDWARD, 2505 GREENLEAF BLVD ELKHART 46514	GP	070

WILSON, PAUL, HOBART, 408 NORTH ST LOGANSPOET 46947	GS	030	WOERNER, THOS, EDWIN, 8402 HARCOURT RD STE 705 INDIANAPOLIS 46260	CD	13
WILSON, RALPH, 517 MARY ST EVANSVILLE 47710	GP	296	WOHLFELD, JULIUS, B, 1222 15TH ST BEDFORD 47421	CD	18
WILSON, ROLAND, BYARD, 1207 S LAFAYETTE ST FORT WAYNE 46802	GP	082	WOLF, HARRY, COHEN, 1265 W 86TH ST INDIANAPOLIS 46260	GP	13
WILSON, WYMOND, BURDETTE, BOX 425 MENTONE 46539	GP	166	WOLF, ROBT, ALLEN, 1447 OAK PARK DR MUNSTER 46321	GP	17
WIND, JOS, LEON, 919 E JEFFERSON BLVD SOUTH BEND 46622	DR	258	WOLF, WM, EDWARD, 403 FIRST NATL BANK BLDG LA PORTE 46350	AN	17
WINTER, DONALD, K, 3210 WATLING ST EAST CHICAGO 46312	GP	174	WOLFE, MORTON, FRANCIS, 1919 STATE ST NEW ALBANY 47150	GP	07
WINTER, WM, PERRY, 1390 E COLUMBUS ST MARTINSVILLE 46151	GP	202	WOLFE, NELSON, ALBERT, 205 PROFESSIONAL ARTS BLDG NEW ALBANY 47150	GP	07
WINTERS, PETER, LEE, 8402 HARCOURT RD SUITE 305 INDIANAPOLIS 46260	D	134	WOLFF, LARRY, H, 6860 HOHMAN AVE HAMMOND 46324	GPH	17
WIREY, HAROLD, RAY, 7377 S MADISON AVE INDIANAPOLIS 46227	GP	134	WOLFRAM, DONALD, J, 5716 N PENN ST INDIANAPOLIS 46220	IM	13
WISE, CHAS, LOWELL, BOX 5 CAMDEN 46917	GP	026	WOLVERTON, GEO, M, 647 EASTERN BLVD CLARKSVILLE 47130	FP	03
WISE, WM, R, 2372 LAFAYETTE RD INDIANAPOLIS 46222	GP	134	WONER, JOHN, WM, 390 A ST N E LINTON 47441	GP	10
WISEMAN, EARLE, VANNOY, 6 DURHAM ST GREENCASTLE 46135	GS	242	WONG, NORMAN, FRANCIS, SUITE 3A SQUARE 500 SAGAMORE PARKWAY W WEST LAFAYETTE 47906	GP	20
WISER, MARK, 619 WEST FIRST ST BLOOMINGTON 47401	N	214	WONG, SAM, LIEN TSU, 30 DOUGLAS ST HAMMOND 46320	GS	17
WISSMAN, WM, LEE, 295 LINDEN LANE COLUMBUS 47201	AN	014	WONGSE SANIT, YONG, YUTS, 10806 HENDRICKS PLACE CROWN POINT 46307	AN	17
WITHAM, RICHARD, STEVEN, 1630 S OHIO ST MARTINSVILLE 46151	GS	202	WONGSE-SANIT, VATCHARA, M, 10806 HENDRICKS PL CROWN POINT 46307	AN	17
WIXTED, JOHN, FRANCIS, PRAIRIE CLUB CAMP HAZEL HURS HARBERT MI 49115	OPH	258	WOOD, DONALD, E, 6467 W HOLIDAY DR INDIANAPOLIS 46260	IM	13
WIXTED, JULIA, M LUNDSTROM, PRAIRIE CLUB CAMP HAZEL HURS HARBERT MI 49115	OPH	258	WOOD, OPAL, LESTER, 428 E BLAINE ST BRAZIL 47834	PH	03
WOERNER, LAUREL, JEAN, 8402 HARCOURT RD STE 705 INDIANAPOLIS 46260	IM	134	WOODALL, JOHN, WESLEY, 1302 S MADISON AVE ANDERSON 46011	FP	11

WOODALL, ROBT, LOUIS, 1400 NORTH ST WASHINGTON 47501	PS	296	WRIGHT, JOS, WM, 5506 EAST 16TH ST STE 22 INDIANAPOLIS 46218	OTO	134
WOODARD, ABRAM, S, 665 E 61ST ST INDIANAPOLIS 46220	GP	134	WRIGHT, ROSS, STANLEY, 2900 W 16TH ST BEDFORD 47421	GS	182
WOODEN, THOS, FRANKLIN, 8354 PARKVIEW AVE MUNSTER 46321	AN	174	WU, L Y, FRANK, 8402 HARCOURT ROAD INDIANAPOLIS 46260	PDA	134
WOODS, ARBA, LEONARD, P O BOX 271 POSEYVILLE 47633	OS	234	WU, STEWART, CHIU HAO, 802 LA PORTE VALPARAISO 46383	GS	230
WOODWARD, BEN, E, P O BOX 5166 EVANSVILLE 47715	ORS	296	WURSTER, RICHARD, EDMUND, 5508 E 16TH ST INDIANAPOLIS 46218	U	134
WOODWARD, WM, M, R R 1 BOX 55A WESTVILLE 46391	IM	230	WYLIE, ROBT, REED, 1356 S LAKE PK HOBART 46342	GP	174
WOOLERY, RICHARD, HENRY, 1310 W 16TH ST BEDFORD 47421	AN	182	WYTENBACH, JOHN, EDWARD, 5808 EASTVIEW CT INDIANAPOLIS 46250	OM	134
WOOLFITT, ROBERT, AMOS, 4927 LINCOLN ROAD INDIANAPOLIS 46208	DR	134			
			Y		
WOOLLING, KENNETH, R, 1815 N CAPITOL INDIANAPOLIS 46202	CD	134	YACKO, MICHAEL, LOUIS, 5341 N CHANNING RD INDIANAPOLIS 46226	AN	134
WORK, BRUCE, ALEXANDER, 1252 S JACKSON FRANKFORT 46041	GP	042	YAHNKE, DAVID, GROSS, 2040 DOCTORS PARK COLUMBUS 47201	OBG	014
WORKMAN, BARBARA, E, 2401 UNIVERSITY MUNCIE 47303	R	062	YALE, CHAS, A, 504 S WALNUT ST FAIRMOUNT 46928	EM	098
WORLEY, HENRY, LEE, 601 E SPRING ST NEW ALBANY 47150	OPH	078	YANG, IN, WHAN, 7905 CALUMET AVE MUNSTER 46321	OBG	174
WORLEY, JOS, PAUL, 5839 E WASHINGTON ST INDIANAPOLIS 46219	GP	134	YARLING, JOHN, LEWIS, R R 9 BOX 437 MUNCIE 47302	P	062
WORTH, CLARENCE, W, R R 2 LAUREL 47024	GP	254	YAST, CHAS, JOS, 6111 HARRISON ST MERRILLVILLE 46410	OTO	174
WORTH, ROBT, MILTON, 704 BRAESIDE SOUTH DR INDIANAPOLIS 46260	NS	134	YAW, PETER, BARNETT, WISHARD MEMORIAL HOSPITAL 1001 WEST 10TH ST INDIANAPOLIS 46202	GS	134
WRENN, ROBT, EMMETT, 711 WEST 2ND ST BLOOMINGTON 47401	OBG	214	YEE, LUCIO, CHIONG, 12110 GRANT ST CROWN POINT 46307	GP	174
WRIGHT, CECIL, STUART, 207 BEVERLY TERR APTS ANDERSON 46016	R	186	YEGERLEHNER, ROSCOE, S, 118 JUNIPER COURT WEST LAFAYETTE 47906	GP	286
WRIGHT, JOS, WM, 5506 E 16TH ST INDIANAPOLIS 46218	OTO	134	YERGLER, WILLARD, G, 328 N MICHIGAN ST SOUTH BEND 46601	ORS	258

YIM, YOUNG, SHIN, 9933 PETERSBURG RD EVANSVILLE 47711	PTH	296	YOUNG, JOHN, MC CONNELL, 4535 MARCY LANE NO 261 INDIANAPOLIS 46205	U	134
YINGLING, ROBT, JAMES, 7601 SILVERPINE COURT INDIANAPOLIS 46250	R	134	YOUNG, JOHN, T, 3151 N ILLINOIS ST INDIANAPOLIS 46208	PD	134
YLAGAN, LUIS, B, M R 35 BOX 48 VALPARAISO 46383	AN	230	YOUNG, JOS, WM, 365 E MAIN ST GREENWOOD 46142	GP	158
YOCUM, PAUL, S, 504 BROADWAY GARY 46402	OPH	174	YOUNG, RALPH, HUBERT, 113 E MADISON ST GOSHEN 46526	OM	070
YOCUM, PAUL, STONE, 4826 ALHAMBRA CIRCLE CORAL GABLES FL 33146	GS	278	YOUNG, ROBT, LAWRENCE, 1646 45TH AVE MUNSTER 46321	OPH	174
YOCUM, WM, STONE, 3656 GRANT GARY 46408	GS	174	YOUNG, STEVEN, ROBT, 1807 BOX ELDER CT INDIANAPOLIS 46260	AN	134
YODER, C, RICHARD, 603 OAKLAND AVE ELKHART 46514	PD	070	YOUNGS, PAUL, EARL, 104 PROFESSIONAL ARTS BLDG NEW ALBANY 47150		078
YODER, CARL, JESSE, 103 BROWN ST MIDDLEBURY 46540	GP	070	YUNE, HEUN, YUNG, 1100 W MICHIGAN ST INDIANAPOLIS 46202	DR	134
YODER, DEWEY, DWAYNE, R D 1 PIERCETON 46562	OPH	326			
			Z		
YODER, JONATHAN, GLEN, P O BOX 126 UNITED MISSION TO NEPAL KATHMANDA NEPAL 00606	GP	070	ZALLEN, STANLEY, GEO, 6933 KENNEDY HAMMOND 46323	GP	174
YODER, RICHARD, PHILIP, 303 S MAIN ST BLUFFTON 46714	IM	318	ZARING, BYRON, KINDRED, THE FOUR SEASONS TAYLOR ROAD COLUMBUS 47201	GS	014
YOLLES, ELLIOTT, A, 50 EAST 91ST ST INDIANAPOLIS 46240	OPH	134	ZEIER, FRANCIS, G, 3708 MULBERRY ST EVANSVILLE 47715	HS	296
YONKMAN, GERHARD, FLORIAN, 6525 EAST 82ND ST INDIANAPOLIS 46250	FP	134	ZEIGER, IRVIN, LEWIS, P O BOX 2574 SOUTH BEND 46624	GP	258
YOU, KWANG-DUCK, 1133 HOLLY LANE MUNSTER 46321	TS	174	ZEITLER, PHILIP, S, 1332 W INDIANA AVE ELKHART 46514	ORS	070
YOUNG, CLAUDE, CURTIS, 326 S E 7TH ST EVANSVILLE 47708	OBG	296	ZELL, EVERTSON, HYLE, 320 N MERIDIAN ST INDIANAPOLIS 46204	GS	134
YOUNG, EUSEBIO, C, 5506 E 16TH ST INDIANAPOLIS 46218	IM	134	ZERFAS, CHAS, PERRY-ALLEN, 9107 BRYANT LANE APT 1A INDIANAPOLIS 46250	GP	134
YOUNG, FREDERIC, DOUGLAS, 8809 CRESTWOOD MUNSTER 46321	OPH	174	ZERFAS, PHYLLIS, K CATT, 9107 BRYANT LANE APT 1A INDIANAPOLIS 46250	OS	134
YOUNG, GERALD, STRAUSS, 924 W MAIN ST MUNCIE 47305	PD	062	ZIENCE, JOHN, ALAN, 1202 WOODBRIDGE LANE INDIANAPOLIS 46260	AN	134

ZIMMER, HENRY, JOHN, 3055 POPLAR ST TERRE HAUTE 47803	OM	298	ZORE, JOS, JOHN, 1434 CHESTER BLVD RICHMOND 47374	PD	314
ZIMMER, JOHN, FREDRICK, 1221 E 86TH ST INDIANAPOLIS 46240	PD	134	ZUCKER, EDWARD, 7863 BROADWAY MERRILLVILLE 46410	PS	174
ZIMMERMAN, WM, HAROLD, 14471 CR-48 SYRACUSE 46567	GP	070	ZURCHER, BRIAN, DALE, 3217 LAKE AVE FORT WAYNE 46805	FP	082
ZINK, ROBT, OTTO, 722 W MAIN ST MADISON 47250	GP	150	ZWEIG, ELMER, S, 2015 PEMBEKTON DR FORT WAYNE 46805	GP	082
ZISS, ROBT, C, 216 S E RIVERSIDE DR EVANSVILLE 47713	IM	296	ZWICK, HAROLD, FREDERICK, 227 S 2D ST DECATUR 46733	GP	010
ZIVICH, JOHN, M, 3701 MAIN ST EAST CHICAGO 46312	GP	174	ZWICKEL, RALPH, EDWARD, 400 DARBY DR NEWBURGH 47630	IM	296

HONORARY MEMBERS

Stefan Ansbacher, ScD., Delray Beach, FL
 Arthur G. Loftin, Indianapolis
 Larry L. Pickering, Fort Wayne
 Paul S. Rhoads, M.D., Richmond
 Arthur P. Tiernan, Evansville
 John B. Twyman, Merrillville
 James A. Waggener, Indianapolis

Specialty Codes

The following specialties, including General Practice, are recognized by the American Medical Association:

AM	Aerospace Medicine
A	Allergy
AN	Anesthesiology
BE	Broncho-Esophagology
CD	Cardiovascular Diseases
D	Dermatology
DIA	Diabetes
EM	Emergency Medicine
END	Endocrinology
FP	Family Practice
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GER	Geriatrics
GYN	Gynecology
HEM	Hematology
HYP	Hypnosis
ID	Infectious Diseases
IM	Internal Medicine
LAR	Laryngology
LM	Legal Medicine
ND	Neoplastic Diseases
NEP	Nephrology
N	Neurology
CHN	Neurology, Child
NA	Neuropathology
NM	Nuclear Medicine
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics and Gynecology
OM	Occupational Medicine
ON	Oncology
OPH	Ophthalmology
OT	Otology
OTO	Otorhinolaryngology
PTH	Pathology
CLP	Pathology, Clinical

FOP	Pathology, Forensic
PD	Pediatrics
PDA	Pediatrics, Allergy
PDC	Pediatrics, Cardiology
PA	Pharmacology, Clinical
PM	Physical Medicine and Rehabilitation
P	Psychiatry
CHP	Psychiatry, Child
PYA	Psychoanalysis
PYM	Psychosomatic Medicine
PH	Public Health
PUD	Pulmonary Diseases
R	Radiology
DR	Radiology, Diagnostic
PDR	Radiology, Pediatric
TR	Radiology, Therapeutic
RHU	Rheumatology
RHI	Rhinology
ABS	Surgery, Abdominal
CDS	Surgery, Cardiovascular
CRS	Surgery, Colon and Rectal
GS	Surgery, General
HS	Surgery, Hand
HNS	Surgery, Head and Neck
NS	Surgery, Neurological
ORS	Surgery, Orthopedic
PDS	Surgery, Pediatric
PS	Surgery, Plastic
TS	Surgery, Thoracic
TRS	Surgery, Traumatic
U	Surgery, Urological

In addition to the above specialties the following designation is also used:

OS	Other, i.e., physician designated a specialty other than those appearing above.
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ROSTER OF MEMBERS BY COUNTIES

Physicians are listed in the county medical society in which they hold membership. See alphabetical list for member's address and specialty.

MS

BOZE, ROBT, L,
BURK, JAMES, MERRYMAN,
CARROLL, JOHN, CLAYSON,
DESTER, HERBERT, EDGAR,
DOAN, JOHN, ELDRIDGE,
GIROD, ARTHUR, HENRY,
LEE, HYUNG, SOO,
PARRISH, RICHARD, K,
REPPERT, ROLAND, LE ROY,
RICH, NORVAL, S,
ZWICK, HAROLD, FREDERICK,

EN-FT. WAYNE

ACKER, HERBERT, KARL JOHN,
AESCHLIMAN, WILLIAM, JAMES,
AHLBRAND, ROLAND, CARL,
ALDRED, ALLEN, W,
ANDERSON, GARLAND, D,
ANDREW, JERALD, LEE,
ARATA, JAMES, ANDREW,
ARATA, JUSTIN, E,
ASHMAN, WM, CARL,
AUST, CHAS, HERSHAL,
BAHR, ROBT, ERNEST,
BAILEY, PAUL, PRESTON,
BALL, J, ROBT,
BALL, MARGARET, J HITZEMAN,
BALTES, JOS, H,
BARCH, JOHN, W,
BASH, STEPHEN, ESTAL,
BASH, WALLACE, EUGENE,
BAUMAN, RICHARD, LEE,
BAYAZIT, LUTFI, Y,
BEAMS, RALPH, H CURIE,
BECKER, LOWELL, ERVIN,
BEIERLEIN, KARL, M,
BEIGHTS, RAYMOND, SAML,
BELANGER, ROBT, ALLEN,
BERGHOFF, JAMES, RAYMOND,
BEUTLER, THEODORE, V,
BIERMAN, GILBERT, HENRY,
BILLINGSLEY, JOHN, SMITH,
BIXLER, JAMES, AMOS,
BLICHERT, PETER, A,
BOLLHEIMER, DON, ALLEN,
BOSSARD, JOHN, W,
BOWERS, JESSE, W,
BRANDT, WM, E,
BRAUNLIN, ROBT, JUSTICE,
BRIDGES, WM, L,
BROMLEY, LUMAN, W,
BROSIUS, ROBT, HENRY WM,
BROWN, GARLAND, RICHARD,
BRUCKER, PERRY, ALBERT,
BRYAN, FRANKLIN, ABRAM,
BUCHHOLZ, JAMES, G,
BUCKNER, GEO, DOSTER,
CHAMBERS, ALAN, R,
CHAMBERS, DONALD, CALVERT,
CHASE, JAMES, ALLAN,

CLARK, WM, RUSSELL,
CLARK, WM, RUSSELL,
COCHRAN, HARRY, ADAM,
CONLEY, JOHN, ELLIS,
CONNELLY, JERRY, HUBBARD,
CONNELLY, RICHARD, DONALD,
CONNER, ROBT, ALLISON,
COOK, IAN, HARPER,
COONEY, CHAS, JOHN,
COOPER, B, TRENT,
COTTRELL, ROBT, FRANKLIN,
COWAN, JOHN, THOS,
CRAIG, RICHARD, MORTON,
CRAWFORD, JOHN, N,
CUFF, STEVE, COLLEY,
CULP, JOHN, EWART,
CURRIE, ROBT, WM,
DAHLING, FRED, WALDEMAR,
DATZMAN, RICHARD, C,
DAUGHERTY, H, SAYLER,
DECKER, JEFFRY, R,
DETTMER, ROBT, WAYNE,
DILLON, GARY, P,
DONESA, ANTONIO, BRAGANZA,
DORMIRE, ROBT, DARRELL,
DUNSTONE, HARRY, CARTER,
DYER, JOHN, KELLY,
ECKERT, RUTH, LOUISE,
ELSTON, LYNN, WICKWIRE,
ELSTON, RALPH, WICKWIRE,
EPPS, JAMES, HARMAN,
FELGER, THOS, ALLEN,
FERGUSON, ARTHUR, N,
FIACABLE, JOS, PAUL,
FLAHERTY, ROBT, ANTHONY,
FOX, RICHARD, FREDERICK,
FOY, THOS, DANL,
FRANKHOUSER, CHAS, M A,
FURTADO, ROBT,
GALLAGHER, DANL, F,
GARTON, HARRY, WASSON,
GASTINEAU, DAVID, C,
GERDING, WM, JOHN,
GIESTING, JEROME, RICHARD,
GIFFIN, CHAS, SALEN,
GILBERT, ALAN, RUSS,
GIZE, RAYMOND, WALTER,
GLOCK, MAURICE, E,
GLOCK, STEVEN, R,
GOEBEL, C, WM,
GOULD, JOHN, C C,
GRAHAM, GEO, M,
GRAHAM, JAMES, CLARENCE,
GREEN, ROBT, F,
GREENLEE, ROBT, L,
GRIEST, WALTER, DIXON,
GRIFFITH, HAROLD, RILEY,
GUMBERT, JACK, LEE,
HACKETT, WALTER, GEO,
HAFFNER, HERMAN, GEO,
HALABY, FOUAD, ASSAD,
HALEY, ALVIN, JOHN,
HALL, WM, RICHARD,

HAMILTON, EMORY, D,
HAMILTON, GEO, MILTON,
HANSELL, CHAS, EARL,
HARRIS, JAMES, JAY,
HARSHMAN, LOUIS, POTTER,
HARVEY, HARRY, C,
HASEWINKLE, AUGUST, M,
HASTINGS, WARREN, C,
HATTENDORF, A, PAUL,
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HAYHURST, THOS, ELDON,
HERENDEEN, THOS, LEE,
HERSHBERGER, PHILIP, G,
HICKMAN, DONALD, M,
HICKS, THOS, JCS,
HILL, JAMES, STEPHEN,
HILLERY, ROBT, LEE,
HOETZER, ELDORE, MARTIN,
HOFFMAN, ARTHUR, F,
HOOG, JOHN, MICHAEL,
HOOVER, JOSEPH, ROYAL,
HOWE, FORDYCE, LEE,
HULL, DE, WAYNE L,
HUMPHREYS, JOHN, LESLIE,
IRMSCHER, GEO, W,
IRMSCHER, JANE, MC MULLEN,
JACKSON, JAMES, WOODROW,
JACKSON, JOHN, F,
JENSEN, ROBT, EUGENE,
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JOHNSTON, RICHARD, M,
JONTZ, JOE, GORDON,
JONTZ, RICHARD, LEE,
JOSLIN, GEO, DAVID,
JUERGENSEN, RICHARD, BOWMAN,
JURGENSEN, WALTER, T,
KAMMEYER, WM, ALLEN,
KAROL, HERBERT, JAY,
KAUFMAN, JULIAN, ROWE,
KECK, CARLETON, ALLEN,
KEMPLER, NORMAN, ALAN,
KENT, RICHARD, NELSON,
KEYES, ROBT, C,
KILGORE, BYRON, W,
KIM, SUNG, SOO,
KIMBROUGH, ROBERT, F,
KLEIFGEN, WM, A,
KLEOPFER, RONALD, G,
KNIGHT, LEWIS, W,
KRUEGER, JOHN, EUGENE,
LA SALLE, WILLIAM, B,
LADIG, DONALD, STEES,
LAKER, GENE, CARROLL,
LAKER, RICHARD, JOHN,
LAMPE, ELFRED, H,
LARMORE, ROBERT, HUGHEL,
LEE, JOHN, W,
LENK, GEO, GUSTAVE,
LENTZ, WM, CHAS,
LLOYD, ROBT, PAUL,
LOGAN, RICHARD, S,
LOHMAN, ROBT, M,
LOVE, VINCENT, LOGAN,

ALLEN-FT. WAYNE
 LUCAS, JOHN, THOMAS,
 LUCKEY, JAMES, EDWARD,
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 MACKEL, FREDERICK, O,
 MACKEL, JERRY, L,
 MALDIA, GODOFREDO, MAYUGA,
 MANN, RICHARD, EUGENE,
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 MARTIN, JOHN, PHILLIP,
 MC ALEAVEY, PATRICK, JOS,
 MC ARDLE, MICHAEL, L,
 MC CALLISTER, JOHN, WM,
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 MC COY, ROY, RALSTON,
 MC DOWELL, GEO, ARNOLD,
 MC DOWELL, RICHARD, LEE,
 MC EACHERN, CECIL, G,
 MENSCH, JAMES, R,
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 MEYER, THEODORE, OBED,
 MILLER, DON, EUGENE,
 MILLER, EDWARD, DWAYNE,
 MILLER, J, THOS,
 MILLER, KENNETH, DEVON,
 MILLER, RICHARD, HENRY,
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 MORTENSON, LELAND, JAMES,
 MUELLER, LAWRENCE, W,
 MUHLER, JOSEPH, CHARLES,
 MUNOZ, JOSE, CUI,
 MUSSELMAN, ROBT, H,
 NELSON, JAMES, BERT,
 NILL, JOHN, HENRY,
 NOLAN, GERALD, ROBT,
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 O'ROURKE, CARROLL,
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 PANCNER, RONALD, JERRY,
 PARROT, DONALD, JEROME,
 PASALICH, JOHN, NOVAK,
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 PEARSON, HUEY, LAWRENCE,
 PERRIN, KERMIT, FLOYD,
 PICKETT, MERLE, ELMER,
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 PRIDY, MARVIN, EUGENE,
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 REED, JOHN, DAVID,
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 RICHARDSON, JOS, HILL,
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WEINLAND, GEO, CHITTY,
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WILLHITE, LARRY, GALE,
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YAHNKE, DAVID, GROSS,
ZARING, BYRON, KINDRED,

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CODDENS, AVERY, L,
LEAK, ROBT, H,
MILLER, DAN, TUCKER,
SCHEURICH, MANLEY, KING,
SCHEURICH, VIRGIL,

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BAILEY, LAWRENCE, S,
BASSETT, MARGARET, ANN,
BOYER, DON, W,
COONS, RITCHIE,
HARVEY, RALPH, JOHNS,
HARVEY, VERNE, K,
HODGES, CHAS, DAVID,
HONAN, PAUL, REVERE,
KERN, CLARENCE, GERALD,
LOVETT, HARVEY, D,
MUKHTAR, FUAD, A,
PORTER, JOHN, R,
SCHAAF, ALVIN, DAVID,

ROLL

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ELLER, ALVAN, LA VERNE,
MC LAUGHLIN, JAMES, R,
PETRY, THOS, NEAL,
SEESE, ROBT, M,
WAGONER, DON, JARED,
WAGONER, GEO, WESLEY,
WAGONER, MARILYN, L ASHER,
WISE, CHAS, LOWELL,

S

BAILEY, EARL, W,
BEAN, JOS, STRATTON,
BOYD, CARL, RITTER,
BREWER, ROBT, ALLEN,
CALISTO, RUBEN, A,
CHENG, SYLVIA, SIU-FAN,
CHU, JOHNSON, C S,
ECKERT, RUSSELL, ALOIS,
FREDERICK, JOS, A,
GLENDEING, RICHARD, L,
HALL, BERNARD, RICHARD,
HILLIS, LOWELL, JOS,
HORNING, RICHARD, R,
HOWARD, JOS, DANL,
JONES, JOHN, CARL,
KARNAFEL, EUGENE, THADDEUS,

KING, JAY, M,
LUXENBERG, EDWIN, RALPH,
MAMARIL, BLAS, FLORES,
MILLER, GARY, LEE,
MORRICAL, DAVID, L,
MORRICAL, RUSSELL, J,
NEWCOMB, WM, KENDALL,
PARKER, E, CAMILLE KILLIAN,
PARKER, FRANCIS, WM,
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PFUETZE, MAX, ENSIGN,
VIZCARRA, RUBEN, FABIAN,
WILLIAMS, EARL, KENNETH,
WILSON, PAUL, HOBART,

CLARK

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BAUTISTA, WARLITO, AVILES,
BIZER, MIER, A,
BRILL, JOS, B,
BUEHLER, GEO, MICHAEL,
CANNON, DAVID, R,
CARLBERG, DALE, LEVAN,
CARR, JOE, HENDERSON,
CLARK, WM, B,
COSIO, JULIO, ELIO,
DUQUE, FAUSTO,
ELY, CECIL, W,
FORSEE, NORMAN, EDWARD,
FULTZ, ROY, LEE,
GOLDEN, WM, YOUNG,
GOODMAN, ELI,
GREENE, WM, RAY,
GUTMANN, GORDON, LIEBREICH,
HADDAD, ROLANDO, IGNACIO,
HARGETT, HERBERT, P,
HEIDEMAN, HARRY, DAVID,
HINES, KENNETH, EARLE,
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HUSSAIN, MOHAMMED,
IGNACIO, OLEGARIO, J,
JIMENEZ, PEDRO, L,
JOHN, MAURICE, EDWARD,
LEGA, ROBT, EUGENE,
MASSER, FRANCES, JOAN,
MAYHUE, HUGH, WAYNE,
MC CLOUD, L, C,
MEYER, CLAUDE, JAMES,
MILLAN, JOSE LITO, LECAROS,
MUDD, JOS, PAUL,
OCA, CLEMENTE, FERNANDEZ,
RAMOS, LEONARDO, POSADAS,
REED, EDESEL, SHERWOOD,
RIEHL, RICHARD, EMIL,
ROBERTSON, ROBT, E,
ROBY, ALMA, LEE,
RUDWELL, GEO, HENDERSON,
SHINA, HASSI,
STURGIS, DONALD, GRIFFES,
THOMPSON, W, TURTON,
TOMLIN, JERROLD, E,
TORRES, JOSE, C,
WILLNER, ALAN,
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CLAY

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FARID, RAHIM,
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OEHLER, NANCY, LEE MARTIN,

OEHLER, ROBT, CURTIS,
SARKAR, DIPPA,
SHATTUCK, JOHN, CHAS,
WEBSTER, ROBT, KENTON,
WOOD, OPAL, LESTER,

CLINTON

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BUSH, CHAS, EDGAR,
DUPLER, LEE, FORREST W,
DYKHUIZEN, THEODORE, A,
ERDEL, MILTON, WM,
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HEDGCOCK, ROBT, ANDREW,
PIPPINGER, WAYNE, GRISE,
STOUT, HARRY, T,
WORK, BRUCE, ALEXANDER,

DAVIESS-MARTIN

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BECK, JAMES, PHILLIP,
CHATTIN, ROBT, EARL,
DAVIS, THOS, WM,
HEYMANN, ROBT, LAWRENCE,
LETT, E, BRISCOE,
LINDSAY, HAMLIN, BERRY,
NORTON, HORACE,
PIERCE, WM, J,
RANG, ROBT, HALTER,
ROSS, GLENN, ELRICK,
SCHAFFER, WM, CHAS,
SEARS, DON, ALVIN,
SEAT, MARSHALL, H,

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BOWEN, GERALD, THOS,
CONRAD, HENRY, WEBB,
DE PALMA, BRUNO,
DIZON, RUSTICO, HIPOLITO,
FESSLER, GORDON, SOISTER,
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GILL, HARBANS, SINGH,
HOUSTON, FRED, DURMENT,
LINDGREN, IVAN, THURE,
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MC NEELY, MATTHEW, J,
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MYERS, RONALD, LEE,
PFEIFER, JAMES, MORRIS,
RAHMAN, SHEIKH, ABDUL,
RHODES, ALFRED, KEITH,
SCUDDER, GARY, EVANS,

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DOMINGO, RICARDO, C,
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MORRISON, JAMES, TREVOR,

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 COVELL, HARRY, MENLO,
 EDWARDS, JOHN, ROBT,
 GRABER, BENJ, ROBT,
 HARVEY, JOHN, CHRISTIE,
 HATHAWAY, CLAYTON, B,
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 HINES, JOHN, HENRY,
 HIPPENSTEEL, HARLAND, V,
 HUGHES, WM, BRADLEY,
 JINNINGS, LOREN, EARL,
 KANTZER, FLOYD, BERNHARD,
 NOVY, CHAS, AUGUST,
 ROGERS, EVERETT, EARL,
 SHULTZ, CLIFFORD, JAMES,
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 ALEXANDER, JACK, LEE,
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 BOTKIN, CLYDE, GARRETT,
 BRANAM, GEO, EVERETT,
 BROWN, LELAND, G,
 BROWN, STEWART, DALE,
 BROWN, THOS, MARTIN,
 BURNS, ANTHONY, JOHN,
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 CAUDILL, RODNEY, C,
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 CLOUSE, JOHN, FRANKLIN,
 COLE, LARRY, GENE,
 COOLEY, PAUL, PHILLIP,
 COOPER, JOHN, FREDRICK,
 COULON, THOS, FRANCIS,
 COULTER, MERLIN, KENNETH,
 COVALT, WENDELL, EARL,
 CULLISON, JOHN, L,
 CURE, ELMER, T,
 DERSCH, DAVID, MATHEWS,
 DIETZ, DAVID, JACKSON,
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 HIGH, RALPH, LESLIE,
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 KALKER, MORTON,
 KAMMER, GRACE, E CLEM,
 KIRSHMAN, FORREST, EARL,
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 KOSS, KENNETH, WM,
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 LAWSON, LAWRENCE, JOS,
 LAWTON, DENIS, FREDERICK,
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 MC CONNELL, THOS, LEE,
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 MONTGOMERY, LALL, G,
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 NEWNAM, PHILIP, EDWARD,
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 PAFF, JAMES, RICHARD,
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 BROWN, THOS, CISEL,
 DAWKINS, PHILLIP, ROSS,
 DREW, DANL, CONNOR,
 GARTNER, JOSE, C,
 GOOTEE, FRANCIS, HUGH,
 GOOTEE, THOS, H,
 GUTIERREZ, GERMAN,
 HAKAMI, MOHAMED, TAGHI,
 HELD, GEO, ARTHUR,
 KEMKER, BERNARD, PERKINS,
 KLAMER, CHAS, H,
 LEON, MARIO,
 LUKEMEYER, ST, JOHN,
 MAGBAG, WENCESLAO, G,
 PLOETNER, EDWARD, JOS,
 RAI, SWAROOP,
 RENDEL, JEFFRY, CHAS,
 SALB, JOHN, PAUL,
 SCALES, ALLEN, DEARING,
 WAGNER, ARTHUR, L,

ELKHART

ARLOOK, THEODORE, DAVID,
 ASHTON, ROMNEY, WM,
 ATWOOD, WM, HENRY,
 BARNES, JAMES, V,
 BENSON, JAMES, EDMUND,
 BIGLER, FREDERICK, W,
 BILLINGS, ELMER, RAY,
 BLOOM, GEO, ROBT,
 BOLING, RICHARD, CLAYTON,
 BOSLER, HOWARD, AARON,
 BOWDOIN, GEO, EDWARD,
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 BOWSER, PHILIP, GORTNER,
 BUDDRUS, DAVID, J,
 CAIN, JEFFREY, L,
 CAMPBELL, PATRICK, B,
 CASSIM, RECHAD, M,
 CHANDLER, LEON, HARVEY,
 CLARK, JACK, PROW,
 CLASSEN, PETE, R C,
 COMPTON, WALTER, AMES,
 CONKLIN, RAYMOND, LE ROY,
 CORMICAN, HERBERT, LEROY,
 CRAIG, ROBT, ALEXANDER,
 DE FRIES, JOHN, J,
 DEW, DANL, CHING-YEE,
 DOVEY, EDWARD, G,
 DURHAM, THOMAS, E,
 ECHEVERRIA, R, E,
 ELLIOTT, THOS, A,
 ELLIS, ROBT, KEITH,
 FEAR, OLAN, DE WITT,
 FINFROCK, JAMES, D,
 FOSBRINK, EPHRAIM, L,
 FRIESEN, GENE, WELDON,
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 GLUCKIN, JAMES, ELLIS,
 GRABER, ALVIN, RAY,
 GRABER, DONALD, D,
 GRABER, VIRGIL, R,
 GREENLEE, JAMES, ROBT,
 GUNDERSON, SHAUN, DENNIS,
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CHART
HARTMAN, CLAUDE, EDWARD,
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HORSWELL, RICHARD, GLENN,
HURLEY, JAMES, W,
IVY, JOHN, H,
JONES, ROBT, B,
KENDALL, FOREST, MACK,
KESIM, MUFIT, HUSAM,
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MC ART, BRUCE, A,
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MILLER, JAMES, RALPH,
MILLER, SAML, T,
MINTER, DONALD, LEE,
MISHKIN, IRVING,
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O'DONOVAN, CORNELIUS, J,
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PAINE, GEO, ELSNER,
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PAPADOPOULOS, A, P,
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PETERSON, JAMES, ARTHUR,
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QUILTY, THOS, JAMES,
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REEDY, STANLEY, GENE,
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RUPE, LLOYD, O,
SCHEER, ALEXANDER, L,
SMUCKER, ERNEST, EDWARD,
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SPRAY, PAGE, EDWARD,
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TROYER, DANA, O,
TURNER, JOHN, PATRICK,
UNZICKER, ROGER, GENE,
WEYBRIGHT, WM, LEE,
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YODER, CARL, JESSE,
YODER, JONATHAN, GLEN,
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HIRSCH, THEODORE,

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FLOYD

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FISHER, PIERRE, JAMES,
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JOSHI, PRAKASH, NARAYAN,
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REID, JAMES, DONALD,
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RHAMY, DONALD, EUGENE,
RHORER, JOHN, GILBERT,
RIFNER, EUGENE, SYMONS,
SHAH, AJIT,
SHOEMAKER, RICHARD, L,
SHROCK, ETHAN, ELLSWORTH,
SHUCK, WILLIAM, ARTHUR,
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WILSON, NED, ARLAN,
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GREENE

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ROTMAN, SAM, ISSAC,
TRAN, LAU,
WONER, JOHN, WM,

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BILODEAU, RICHARD, GERARD,
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MABEL, THOS, ARTHUR,
MANHART, DOYLE, BASLER,
MIRKES, SEYMOUR, HOWARD,
MYERS, JERRY, RICHARD,
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SAPERSTEIN, MORRIS,
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HANCOCK

ARIVE, FLORO, FERNANDO,
BEESON, WILBUR, P,
CAGLE, BOB, R,
ENDICOTT, WAYNE, H,
FARRELL, JOHN, JOS,
GARRISON, JAMES, L,
HAAS, RAY, ALLAN,
HENN, RAY, ANTHONY,
HENSLEY, HARRY, THOS,
HUNTER, DONN, R,
KIRBY, TED, C,
KUHN, ROBT, WOODROW,
MATLOCK, CARL, KENT,
MILLER, JOS, A,
MOENNING, JOHN, EDWARD,
REA, RALPH, LEWIS,
REED, DONALD, WAITE,
RHYNEARSON, HAL, ROBT,
SHARP, GARY, CHAS,
SINGCO, BIENVENIDO, C,
SMITH, JOHN, HAROLD,

HARRISON-CRAWFORD

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BROCKMAN, WILFRED, J,
DILLMAN, CARL, EDWARD,
DUKES, DAVID, J,
JORDAN, RICHARD, ALLEN,
MARTIN, SAML, W,
MAY, RICHARD, MILTON,
SEIPEL, STANLEY, F,

HENDRICKS

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CALHOON, JOHN, PAUL,
CLARK, ERIC, DANL,
COHEN, IRVING,
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EDWARDS, WILLIAM, A,
ELLIS, LYMAN, HALL,
HADLEY, DAVID, M,
HAGGARD, DAVID, BENSON,
HEINLEIN, CARL, LORISTON,
HIBBELN, THOS, J,
KERLIN, JOS, C,
KIRTLEY, ROBT, WAYNE,
KOCH, ELMER, L,
LONG, MALCOLM, DARRELL,
MC DOUGAL, ROBT, A,
MITMAN, URSULA, E,
OCHSNER, EDWARD, C,
SCAMAHORN, JAMES, OSCAR,
SCAMAHORN, MALCOLM, O,
SCUDDER, ARTHUR, NELSON,
STAFFORD, WM, CLAYTON,
TAYLOR, ROBT, LEONARD,
TERRY, LLOYD, SHERMAN,
WAGNER, WM, LESLIE,
WALKER, THOS, MARTIN,

HENRY

BURNETT, ARTHUR, BAKER,
CAIN, DAVID, ROBINSON,
DYE, CLOYD, LEROY,
EASTER, JAMES, NEIL,
FISHER, JOHN, EDWARD,
FOSTER, RAY, T,
GATMAITAN, ALEJANDRO, V,
GRANT, PHYLLIS, ANN FENN,
HEILMAN, WM, CLYDE,
HILL, KENNETH, GRIMES,
KINKADE, PAUL, TERRENCE,
LENTINI, NINO, RUDOLPH,
LIFE, HOMER, LAWRENCE,
MC ALLISTER, ALLAN, J,
MC DONALD, FRANK, C,
MC ELROY, JAMES, STEWART,
MC KEE, ROY, G,
MILLER, WM, AMON,
MOREC, GEO, JAMES,
PAZ, LUIS, AUGUSTO,
POLLACK, SEYMCUR, LESTER,
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STEUSSY, CALVIN, N,
STRICKER, PAUL, JAMES,
VALENA, DOMINADOR, V,
VIVIAN, DONALD, E,
WIATT, LEONARD, H,
WILHELM, GUIDO, PAUL,

HOWARD

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ARTIS, MYRLE, EVERETT,
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BLUE, EARL, ROBT,
BOWERS, COPELAND, C,
BOWMAN, JOHN, ALDEN,
BRADLEY, RICHARD, VINCENT,
BROWN, RICHARD, J,
BRUEGGE, THEODORE, JOS,
CHOI, STEPHEN, S,
CLEVINGER, WM, GERALD,
CONLEY, THOS, MARION,
CRAIG, REUBEN, ALLEN,
CRAWFORD, THEODORE, R,
DAS, AMAL, KUMAR,
DAVID, DELFIN, PARAS,
DENTON, LARKIN, D,
DOSS, JEROME, FAULKNER,
EARL, MAX, MARKLEY,
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ERICSON, HOMER, STANLEY,
FIELDS, DONALD, LEE,
FRETZ, RICHARD, CARL,
GABOYA, RUBEN, READ,
GOLPER, MARVIN, NORMAN,
GOOD, RICHARD, PETERSON,
GRANDA, ARMANDO, BERNARDO,
GROTHOUSE, CARL, B,
GUIN, JERE, DONALD,
HALFAST, RICHARD, W,
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HIGGINS, JACK, WAYNE,
JEWELL, GEO, MONROE,
KING, FRANK, KARL,
KREMERS, GEO, ADAM,
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LONGSHORE, ROBT, EUGENE,

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PESARILLO, SERVANDO, N,
PHARES, ROBT, WESLEY,
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PRATHER, PHILIP, E,
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RADPOUR, SHOKRI,
REUL, GEO, MARVIN,
ROEGNER, DONALD, LEE,
RUDICEL, MAX, W,
SCHERSCHEL, THOS, ROGER,
SEKULICH, MILO, M,
SENN, RICHARD, THOS,
SMITH, CHAS, FELPS,
SPANGLER, JESSE, SAML,
TAPNIO, ROGELIC, ORDONEZ,
TIGNOR, STERLING, PRESTON,
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WESTERFIELD, GORDON, LEE,
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CLUNIE, WM, ADAMS,
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KAY, JOHN, BOYD,
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PEARE, REEVE, BERTON,
SHAH, KISHORI, P,
SHAH, PIYUSH, J,
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WHEELER, BARTH, EDMONSON,

KSON

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BOSCH, RALPH, OTTO,
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GRAESSLE, HAROLD, PETER,

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MC GILL, JOEL, LEWIS,
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WIETHOFF, RICHARD, ALLEN,

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O'BRIEN, FRANCIS, EUGENE,
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LY, LILY, ANN U H,
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MODISETT, MARCELLA, L S,
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STEIN, RICHARD, H,
STEWART, J, FRANK, W,
STEWART, RALPH, WM,
VAUGHN, WALTER, R,
VON DER LIETH, WM, P CAREW,

KOSCIUSKO

ARFORD, JOHN, ELMORE,
BAUM, JOHN, RUSSELL,
CROSS, RICHARD, WESLEY,
DU BOIS, CHAS, CLIFFORD,
HAINE, DAVID, W,
HASHEMI, HOSSEIN,
HAYMOND, GEO, M,
KEOUGH, THOS, FRANCIS,
MATHEU, HERACLEO, I,
MOSE, ARTHUR, LEE,
PARKE, WM, COULTER,
PULLMAN, GEO, R,
ROS, GEORGE, A,
SNIDER, ROLAND, SIMPSON,
WILSON, WYMOND, BURDETTE,

LAGRANGE

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LEHMAN, KENNETH, MAX,
MARTIN, ALLEN, S,
MELLINGER, MICHAEL, OWEN,
SPINDLER, RICHARD, GILBERT,
STUDEBAKER, LLOYD, R,

LAKE

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ABRAMSON, ALLAN, LAWRENCE,
ACOSTA, AMADOR, ALFONSO,
ACOSTA, CONSTANCIO, BELO,
ADAD, WAHBI,
ADLER, FRED,
ALFANO, PAUL, ANGELO,
ALLEGRETTI, MICHAEL, L,
ALMASE, RODOLFO, MEDENILLA,
AMBROZAITIS, KAZYS, GEO,
AMICO, PASQUALE, JOS,
ANG, ROBERT, T,
ANGEL, VIRGIL, E,
ANGELES, ULDARICO, A,
ANGULO, EDILBERTO, D,
APELLIDO, LIBERACION, L,
ARBEITER, HERBERT,
ARROWSMITH, JAMES, LLOYD,
ATASSI, BASSEM,
AUBURN, RICHARD, P,
AYOUB, ADEL, HABIB,
BAGHDASSARIAN, SAHAG, ARAM,
BALAGUER, CARMEN, V S,
BALTER, EUGENE, LEE,
BARRON, ELMER, ABRAHAM,
BARTHELEMY, DOUGE,
BARTON, REGINALD, RAYMOND,
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BECKMAN, ARTHUR, JOS,
BECONOVICH, ROBT,
BEHN, WALTER, MARTIN,
BEISER, GEO, DAVID,
BENCHIK, FRANK, AUGUST,
BENDLER, CARL, HENRY,
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BERNARD, MARVIN, R,
BERUBEN, MIGUEL, F,
BEST, ROBT, C,
BICALHO, JOSE, FERNAL,
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BILLS, ROBT, NOEL,
BLANCO, RAMON, M,
BLEZA, MAXIMO, TULABOT,

BOMBAR, LESLIE, EUGENE,
BOONE, CLARENCE, WAYNE,
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BORNSTEIN, HERSCHEL,
BOYS, FAY, FRANK,
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BRANDMAN, HARRY,
BRASOVAN, SRBISLAV, N,
BRAUER, ABRAHAM, A,
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BRENNAN, WM, CLARENCE,
BRENNER, HOWARD, B,
BRINCKO, JOHN,
BRODERSEN, JAMES, DENNIS,
BROOMES, EDWARD, LOUIS,
BROWN, LEO, RALPH,
BRUBAKER, THOS, ALBERT,
BRYANT, EDWARD, GAREY,
BUKATA, PEDRO,
BUNAG, HOMER, UY,
BURACK, WALTER, R,
BURTON, ROBT, L,
BUYER, RICHARD,
CABRERA, PELAYO, BONSON,
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CHA, JIN, SUCK,
CHAE, THOS, C,
CHANG, IL, WOONG,
CHEN, SHU-FANG,
CHERMEL, IVAN, LEONARD,
CHIP, JEROLD, NORMAN,
CHIVAPRUK, CHARAT,
CHO, SUK-IN,
CHONA, ALFRED,
CHOSLOVSKY, SYDNEY,
CHUA, FARIDA, ISIP,
CHUA, FELIPE, S,
CHUBE, DAVID, DEMARET,
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CLARO, JOS, JOHN,
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COTTER, EDWARD, RICHARD,
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DAVIDSON, CHAS, O'DELL,
DE LA COTERA, FEDERICO, G,
DE LA PAZ, OSCAR, GUEVARA,
DE MELO, LUIZ, PEREIRA,
DE PORTER, LOUIS, ALPHONSE,
DEEN, CHRISTOPHER,
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DHANA, SRIKIETR,
DIAMOND, HOWARD, MICHAEL,
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DIMITROFF, LAMBRO,
DIVCIC, BORIVCJ, SRETEN,
DIZON, BELEN, RODRIGUEZ,
DIZON, GUALBERTO, REYES,
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EBERT, TERRY, WAYNE,
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ENGLISH, HUBERT, MORTON,
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ESPINO, JOSE, CANCIO,
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FISHER, THOS, FORREST,
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FOX, JACK, MILLER,
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FRIESKE, DAVID, ALLEN,
GABATO, MANUEL, BARDOS,
GALANTE, ALBERT,
GALANTE, GLORIA,
GEHRING, THOS, ALBERT,
GEVIRTZ, MILTON, BERNARD,
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GIVEN, GILBERT, Z,
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GOEL, SARLA, KANAL,
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GOLDING, ROBT, FISCHER,
GOLDSTONE, ADOLPH,
GOLDSTONE, JOS,
GOLDSTONE, SIDNEY, RICHARD,
GOMEZ, CESAR, MORALES,
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GOODWIN, THOS, GERALD,
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GORDON, ROGER, DREW,
GORELIK, MARCOS,
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HAN, DANL,
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HEHEMANN, WM, VINCENT,

LE
HELMS, CHAS, EDWARD,
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HUSTED, ROBT, G,
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JAO, RODOLFO, L,
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KIM, MU, SHIN,
KIM, YOUNG, ROCK,
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KING, ROBT, W,
KINO, YOICHI,
KIT, WALTER,
KMAK, CHESTER, JOHN,
KOBRI, MEYER, WALTER,
KOLETTIS, JOHN, GEO,
KOPCHA, JOS, EDWARDS,
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KUHN, ARTHUR, J,
KULSAK DINUN, CHAIRAT,
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LAUTZ, HERBERT, A,
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LEMAN, EUGENE,
LEVIN, HARVEY, JOS,
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LEWIS, ROSA, HILDA,
LILAGAN, FLORENTINO, RAMOS,
LIN, SHOU-GEM,
LOH, HWEI-YA, CHANG,
LOH, JEROME, WEI-PING,
LONA, MARCO, ANTONIO,
LOPEZ, FILEMON, PASION,
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LOVELL, MARTIN, HUTSON,
LUK, PETER,
LUNDEBERG, RALPH, ALVIN,
LUTZ, ANDREAS,
LUTZ, GEORGIANNA,
LYTWAKIWSKY, ANATOL,
MADARANG, NAPOLEON, M,
MADLANG, RODOLFO, M,
MADRILEJO, NORA, GUEVARA,
MADRILEJO, ROBERTO, B,
MANGAHAS, JOVENCIO, P,
MANGAHAS, VIOLETA, RIVERA,

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MANSUETO, MARIO, DANL,
MANZANO, EDMUND, V,
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MARQUINEZ, ADOREACION, A,
MARSHALL, WILBUR, JAMES,
MARTINO, ROBERT, S,
MARTINEZ, NAPOLEON, A,
MASON, EARL, JAMES,
MASON, JOHN, CHAS,
MASON, RICHARD, L,
MASSUDA, YACOB, U,
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MC DONALD, WALTER, EVERETT,
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MEDINA, HERBERT, LEONARDO,
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MILLAN, FELIX,
MILLER, DONALD, C,
MILOS, ROBT, JOS,
MIN, DAVID, PYONG-WHA,
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MINKIN, RONALD, BLAINE,
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MITCHELL, GEORGIA, BONE,
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MOLENGRAFT, CORNELIUS, J,
MONTES, HERMINIO, Y,
MONTUORI, GIULIA,
MOORE, EDWIN, GRIFFEN,
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MOSWIN, JACK, ARTHUR,
MURILLO, HERBERT, LAURON,
MURPHY, JOS, FRANCIS,
NAKAMURA, TAKAMITSU,
NAZON, YVON,
NEAL, LEONARD, WILSON,
NEER, DAVID, DREW,
NELSON, WILFRED, ARTHUR,
NICOSIA, JOHN, B,
ORNELAS, JOS, PAUL,
PALMER, BARRON, M F,
PAMINTUAN, FLORINO, GANDO,
PAPPAS, EDDIE, THOS,
PARRATT, LOUIS, WARDROP,
PATEL, RASHMI, CHIMANLAL,
PATEL, UPENDRA, H,
PAUL, EUDELL, GEO,
PAVELKA, RONALD, PETER,
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PEIFFER, GERALDINE, M,
PENN, ROBT, ALLAN,
PESIGAN, CONRADO, SISON,
PETTIS, ARTHUR, GLASCO,
PHILLIPS, DONALD, MICHAEL,
PHITHAYANUKARN, JOSEFINA,
PILLAY, VIJAYAPRASANATHAN,
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PLATIS, JAMES, MARK,
POLITE, NICHOLAS, LOUIS,
PORTNEY, FRED, R,
POTTI, T, K KRISHNAN,
PREMUDA, FRANKLIN, FRED,
PRUITT, JACOB, E,
PURCELL, RICHARD, J,

RAHMANY, MOHAMMAD, ASEF,
RAMKER, DANL, THEODORE,
RASCH, GEO, C,
RAWLINS, CAROLYN, N MANN,
RAWLINS, STEVEN, JOE,
RAYMUNDO, LUCIANO, CABATE,
REED, JOHN, JOS,
REED, RONALD, RILEY,
REITMAN, PAUL, HENRY,
REMICH, ANTONIO, CHAS,
RENDEL, DONALD, T,
REPAY, WALTER, ALLEN,
REYES, ANGEL, I,
RHIND, ALEXANDER, WM,
RIESER, ALOYS, MARTIN,
ROIG, JOSE, HUGE,
ROSENBLUM, PHILIP, JACK,
ROSS, DAVID, EUGENE,
ROTH, LEO,
RUBIN, SIMON, SYRIL,
RUDSER, DONALD, HARRY,
RUSSO, ANDREW, ESCHER,
RYAN, HUBERT, JOS,
SAAVEDRA, BERNARDO,
SABO, WILLIAM, J,
SALA, JOS, JOHN,
SALA, WALTER, RUDOLPH,
SALEM, IBRAHIM, MITRE,
SANTARE, VINCENT, JOS,
SCHAROFF, JAY, ROBT,
SCHLESINGER, DANL, J,
SCHMITT, ROBT, J,
SCHULFER, RICHARD, J,
SCHULZ, KURT, J E,
SCHWARTZ, JACK,
SCHWARTZ, MAGDA,
SCULLY, JOHN, T,
SEMERDJIAN, ARAM,
SERNA, CARLOS, A,
SERRANO, JOSE, FLORENTINO,
SHAPIRO, JOS,
SHAPIRO, SEYMOUR, WM,
SHETTY, DAYANANDA, M,
SHULRUFF, HARRY, I,
SIEKIERSKI, JOS, M,
SLAMA, GEO, FRANCIS,
SMEJKAL, JERALD, J,
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SMITH, JERALD, E,
SMITH, ROBT, D,
SMITH, THEODORE, J,
SO, JAMES, L,
SOLIS, ROGER, VALBERG,
SOMANI, INDRA, KUMAR,
SONG, JOHN, YE KUN,
SORAK, KATICA,
SRI, PRASIT,
SROKA, STANLEY, JOS,
STASICK, MURRAY,
STECY, PETER,
STEELE, EVERETT, B,
STEEN, LOWELL, HARRISON,
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STEWART, PAUL, WAYNE,
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SUWANWILAI, CHAROEN,
SZANTO, PHILIP, A,
TABION, NAPOLEON, C,
TAN, JUAN,
TANRIKULU, ORHAN,

LAKE

TEMPLIN, DAVID, BROWNING,
THEPHASDIN, JIROJ,
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THOMAS, GERALD, JAY,
THUPVONG, CHAWTIPYA, D,
THUPVONG, KOSIN,
TIFFANY, JOS, CALVIN,
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TOWANNASUT, VERAPON,
TOYAMA, TSUYOSHI,
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TROY, JACK, MILTON,
TSAI, SAN, HUA,
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TYRRELL, JOS, J,
TYRRELL, THOS, CARROLL,
UNNI, RAMAKRISHNAN, P,
URBA, VYTAUTAS, VICTOR,
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VALENCIA, MONICO, M,
VALENZUELA, ROBERTO, D,
VALENZUELA, SOFIA, SALOMON,
VANDER WESTHAYSEN, PETER,
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WONG, SAML, NIEN TSU,
WONGSE SANIT, YCNG, YOTS,
WONGSE-SANIT, VATCHARA, M,
WOODEN, THOS, FRANKLIN,
WYLIE, ROBT, REED,
YANG, IN, WHAN,
YAST, CHAS, JOS,
YEE, LUCIO, CHIONG,
YOCUM, PAUL, S,
YOCUM, WM, STONE,
YOU, KWANG-DUCK,
YOUNG, FREDERIC, DOUGLAS,
YOUNG, ROBT, LAWRENCE,
ZALLEN, STANLEY, GEO,
ZIVICH, JOHN, M,
ZUCKER, EDWARD,

LAPORTE

ADEVA, DOLORES, GUIMIERA,
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BACKER, MARY, B YEAGER,
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BREMER, WINDHAM,
CARPENTIER, JAMES, ROBT,
CONSTAN, EVAN,
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DIAN, AUGUST, JOS,
EDWARDS, JAMES, LARKIN,
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ERWIN, WINFORD, ROBT,
FEINN, HARRY, S,
FROST, ROBT, JCS,
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GARDNER, MELVIN, DUANE,
GARDNER, RUSSELL, ALLEN,
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GILMORE, RUSSELL, ADAMS,
HAGENOW, CHAS, FREDERICK,
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HOUCK, RICHARD, JAMES,
JENSEN, JAMES, WALDEMAR,
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KELSEY, ROBT, MOFFAT,
KEMP, JOHN, THEODORE,
KEPLER, ROBT, WENDEL,
KERRIGAN, JOHN, FRANCIS,
KERRIGAN, ROBT, LEE,
KIM, JOON, SUN,
KROCZEK, STEPHEN, ERIC,
KUBIK, FRANCIS, JOS,
LALANI, ABDUL, SULTAN,
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MANNION, RODNEY, ANTHONY,
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MC BRIDE, ROBT, EDMUND,
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MILLER, MAURICE,
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MLADICK, EDWARD, A,
MOORE, WM, GILBERT,
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MUELLER, EDWIN, C,
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SIRUGO, ALDO, CORRADO,
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SPRECHER, JAMES, JOHN J,
STARK, WILLIAM, A,
STILLER, AILEEN, GRIFFIN,
TICSAY, BENVENIDO, V,
VON ASCH, GEO, FREDERICK,
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HUBER, RICHARD, GLEN,
HUI, HANNAH, MAY-TUK,
JOHNSON, WALLACE, D,
KADERABEK, DONAL, JOS,
KERR, DONALD, MILTON,
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NOE, WM, ROBT,
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ODULIO, BRUNHILDA, IRIS,
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SORRELLS, GEORGE, W,
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WALDO, GUY, HAROLD,
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MADISON

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GAHIMER, JOE, EDWARD,
GALLANOSA, ARTURO, G,
GAUNT, EVERETT, WELKER,
HANSON, MARTIN, F,
HENSLEY, BENTON, MOSES,
HOLL, CARL, W,
IRWIN, GERALD, PORT,
JARRETT, PAUL, EUGENE,
JONES, DAVID, GEO,
JONES, JOHN, DAVID,
KEPNER, ROBT, STANLEY,
KING, CHAS, ROSS,
KOPP, WM, R,
LAND, RICHARD, NELSON,
LARMORE, JOS, LOWMAN,
LAUDEMAN, WALTER, A,
LEAHY, HOWARD, JOS,
LEY, LARRY, J,
LIM, NUNILON, CARRANZA,
LITZENBERGER, SAM, W,
LONG, PAUL, LAPPLE,
MARTIN, DAVID, LEE,
MC CURDY, ROBERT, WILLIAM,
MENGELT, THOS, PAUL,
MONEYHUN, JAMES, EMMETT,
MORRIS, ROBT, ALLEN,
MUSNGI, LUCIANO, PESTANAS,
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STARKS, WILLIAM, O,
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WAGONER, JOHN, ROBT,
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 CORTESE, THOS, ANTHONY,
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 DALY, WALTER, JOS,
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 DE ROSA, GUY, PAUL,
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 DENNY, JAMES, WESLEY,
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 DICKSON, CAROLYN, H LUCAS,
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 DOWD, JOS, A,
 DOWNS, KENNETH, R,
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 DUBOIS, DON, RAMON,
 DUGAN, JOHN, RICKWOOD,
 DUGAN, WM, MILLER,
 DUNCAN, STUART, JACKSON,
 DUNKIN, RAMON, SINCLAIR,
 DYAR, EDWIN, WM,
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 DYKEN, MARK, LEWIS,
 EARP, EVANSON, BYERS,
 EATON, EDWIN, RAY,
 EATON, LYMAN, DALE,
 EBERT, J, WAYNE,
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 EDMANDS, ROBT, EMERSON,
 EDWARDS, DAVID, JEAN,
 EDWARDS, JOSHUA, L,
 EDWARDS, JUDITH, ANN JOHNS,
 EDWARDS, WENDELL, LEE,
 EGBERT, HERBERT, L,
 EICHER, PALMER, O,
 ELDRIDGE, GAIL, EDWARD,
 ELKINS, JAMES, PAUL,
 ELLIOTT, DANL, ROBT,
 ELLIOTT, WM, CROMARTIE,
 ELLIS, FORREST, D,

ELLIS, WM, NICOL,
 EMHARDT, JOHN, THILO,
 EMKES, BERNARD, JOHN,
 ESKEW, PHILIP, NEWTON,
 EVANS, FREDERICK, H,
 EVANS, PAUL, VINCENT,
 EVENS, MARVIN, AMOS,
 EVERLY, RALPH, VERNON,
 FAILEY, ROBT, B,
 FARIS, JAMES, VANNOY,
 FARRIS, JOHN, JOS,
 FAUSSET, C, BASIL,
 FECHTMAN, WM, FREDERICK,
 FEENEY, MARTIN, THOMAS,
 FERGUSON, JEFFREY, HALE,
 FERRARA, THOS, ALBERT,
 FERREE, H, LANE,
 FERREE, MARY, M,
 FERRY, FRANCIS, A,
 FEUER, HENRY,
 FINNERAN, JOS, CHAS,
 FISCHER, A, ALAN,
 FISCUS, CLIFFORD, WM,
 FISHER, WM, PAUL,
 FITZGERALD, EDWARD, BRICE,
 FITZGERALD, WM, JOS,
 FLANAGAN, PAUL, M,
 FLANDERS, ROBT,
 FLANIGAN, M, B,
 FLEISCHL, HERBERT,
 FLORA, JOS, O,
 FOLEY, PATRICK, L,
 FOSGATE, HAROLD, L,
 FOSTER, LEE, N,
 FOSTER, LOWELL, GEO,
 FOSTER, RAY, D,
 FRANKEL, GERALD, JOS,
 FRANKEN, EDMUND, A,
 FRANKLIN, WILLIAM, L,
 FREDERICK, TERRY, LEE,
 FREEMAN, MAX, E,
 FRENCH, RICHARD, STEPHENS,
 FROMHOLD, WILLIS, A,
 FRY, ROBT, DE VAULT,
 FULTON, WM, HALL,
 FURMAN, ROBT, H,
 GABOVITCH, EDWARD, ROBT,
 GABRIELSEN, TED, HOWARD,
 GADDY, NELSON, DON,
 GAMBILL, WM, DUDLEY,
 GARBER, J, NEILL,
 GARCEAU, GEORGE, J,
 GARCIA, TIERRY, F,
 GARD, DANL, A,
 GARDINER, SPRAGUE, HEMAN,
 GARDNER, AUSTIN, L,
 GARDNER, FREDERIC, B,
 GARDNER, NORMAN, DAVID,
 GARFIELD, MARTIN, D,
 GARNER, WM, STANLEY,
 GARRETT, ROBT, AUSTIN,
 GAURAND, LAURO, M,
 GEIDER, ROY, AUGUST,
 GEISLER, HANS, EMANUEL,
 GENNA, MARY, MILLER,
 GEORGE, CHAS, LESTER,
 GEORGE, JOHN, LAWRENCE,
 GERTH, ROBT, EDWARD,
 GIBSON, GRETA, MAXINE,
 GICK, HERMAN, HENRY,
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 ILLESPIE, JACOB, EARL,
 ILLIM, PARVIN, DOUGLAS,
 IROD, DONALD, ALFRED,
 LOVER, JOHN, LEE,
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 GRAHAM, JOHN, DOUGLAS,
 GRAHAM, WM, EUGENE,
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 GRAYSON, TED, LINDSAY,
 GREEN, MORRIS,
 GREEN, OSCAR,
 GREENE, MORGAN, E,
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 GRIFFITH, ROSS, EARL,
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 GRISELL, TED, LEWIS,
 GRISELL, TED, WOOD,
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 HUGHES, CHAS, EDGAR,
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 IVERSON, ROBERT, LOUIS,
 JAMES, CHAS, EDWARD,
 JARDINE, DON, ROSS,
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 JAY, ARTHUR, NOTTINGHAM,
 JAY, JAMES, MILTON,
 JAY, STEPHEN, J,
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 JONES, RICHARD, ALLEN,
 JONTZ, JON, PHILLIP,
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 KEENER, GERALD, THERON,
 KELLAMS, JEFFREY, JEROME,
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 KINGSBURY, DAVID, HOMER,
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 KOURANY, OSCAR,
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 LA DINE, CLARENCE, B,
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 LOZOW, DAVID,
 LUCAS, CLARENCE, A,
 LUGINBILL, HOWARD, M,
 LUKEMEYER, GEO, T,
 LUROS, JOHN, THEODORE,
 LYBROOK, WM, B,
 LYNN, GENE, EDISON,
 MAC DOUGALL, JOHN, D,
 MACKENZIE, VERONICA,
 MACKAY, JOHN, EDWARD,
 MADDEN, ROBT, JOHN,
 MADTSON, ALFRED, R,
 MADURA, JAMES, ANTHONY,
 MAGLINTE, DEAN, D T,
 MALACHOWSKI, ROBT, MICHAEL,
 MALIK, MUHAMMAD, IQBAL,
 MAMMEN, HAROLD, W,
 MANDEL, DARREL, SHELDON,
 MANDELBAUM, ISIDORE,
 MANDERS, KARL, L,
 MANION, MARLOW, WM,
 MANN, MORTIMER,
 MANNING, K, RANDOLPH,
 MANZIE, MICHAEL, WM,
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 MARKS, JOHN, SCOTT,
 MARKSTONE, DAVID, HAROLD,
 MARSH, CARL, M,
 MARTIN, LOREN, HAROLD,
 MARTZ, BILL, L,
 MARTZ, CARL, D,

MASBAUM, NED, PAUL,
 MASCHMEYER, ROBT, HENRY,
 MASTERS, JOHN, MELVIN,

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 MAXAM, BEVERLY, TRENT,
 MAXSON, ROY, VERNON,
 MC AREE, FRANCIS, EDWARD,
 MC CALLUM, DONALD, CAREY,
 MC CALLUM, JAMES, JOS,
 MC CARTHY, LEO, JOS,
 MC CARTNEY, DONALD, H,
 MC CLAIN, EDWIN, S,
 MC CORD, GEO, ELLIOTT,
 MC DANIEL, EDWIN, CORR,
 MC DOUGAL, BUD, HOLLAND,
 MC ELROY, JAMES, THOS,
 MC GARVEY, WILLIAM, K,
 MC GRAW, WM, ELMER,
 MC INTYRE, JAMES, MURRAY,
 MC KINLEY, A, DAVID,
 MC LAREN, DANL, EDWARD,
 MC NUTT, CYRUS, CHARLES,
 MC QUISTON, RALPH, J,
 MC QUISTON, ROBT, DOUGLAS,
 MEADE, DONNA, JOAN,
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 MELIN, JOHN, R,
 MELTON, MARVIN, EUGENE,
 MENCAS, LEON, A,
 MENTENDIEK, MARY, ANN,
 MERCHO, JEAN, PHARAON,
 MERICLE, EARL, WM,
 MERRITT, ARTHUR, D,
 MERTZ, JOHN, HENRY O,
 MESHBERGER, FRANK, LYNN,
 MICHAEL, ISAAC, ELDREW,
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 MIKULASCHEK, WALTER, M,
 MILLER, DENNIS, WARREN,
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 MILLER, JERRY, ROLAND,
 MILLER, JOHN, DAVID,
 MILLER, L, HOYT,
 MILLER, ROSCOE, E,
 MILLER, STEPHEN, THOS,
 MOAK, GLENN, D,
 MONN, LARRY, NEIL,
 MOORE, DONALD, FLOYD,
 MOORE, HAROLD, T,
 MOORE, THOMAS, S,
 MOORE, THOS, O,
 MOORES, WM, BRADLEY,
 MOOSEY, NEALE, ANTHONY,
 MORAN, THOS, EDWARD,
 MORETTO, THOS, JAMES,
 MORGAN, MARGARET, ELAINE,
 MORGAN, ROBT, JOS,
 MORIARTY, JOHN, ROBT,
 MORRISON, LEWIS, E,
 MORSE, ROBT, PETER,
 MORTON, JOS, LEWIS,
 MORTON, PHILIP, MONROE,
 MORTON, WALTER, PHILLIPS,
 MOSBAUGH, PHILLIP, GEO,
 MOSER, ROLLIN, HENRY,
 MOSS, BOBBY, LEE,
 MOSS, HARLAN, B,
 MOSS, HERSHEL, C,

MOTHERSILL, MARK, HENRY,
 MOUSER, ROBT, WINSTON,
 MULLER, LULLUS, PETER,
 MULLER, PAUL, FREDERICK,
 MULLER, VICTOR, H,
 MULLINIX, F, MICHAEL,
 MURALI, MAGARAL, S,
 MURRAY, RAYMOND, HAROLD,
 MYERS, CHAS, WESLEY,
 MYERS, ROY, VERN,
 NAGAN, ROBT, FRANCIS,
 NASSER, WM, KALEEL,
 NAVARRO, CASIMIRO, PERALTA,
 NAY, RICHARD, MARION,
 NEED, DAVID, JOHN,
 NEED, LOUIS, T,
 NEED, RICHARD, LOUIS,
 NESTER, HENRY, G,
 NEWMAN, DANL, MARQUETTE,
 NG, ANASTACIO, C,
 NICELY, PAULETTE, ANN G,
 NICHOLAS, DENNIS, J,
 NIE, LOUIS, WM,
 NOHL, JOHN, MARTIN,
 NORDSCHOW, CARLETON, D,
 NORINS, ARTHUR, LEONARD,
 NORMAN, WILLIAM, H,
 NORRIS, MAX, S,
 NOURSE, MYRON, H,
 O'BRIAN, EARL, J,
 OCHSNER, HAROLD, CONRAD,
 OEI, TJIEN, OEN,
 OFFUTT, ANDREW, CARROLL,
 OLVEY, OTTIS, NIEL,
 ONYETT, HAROLD, R,
 OPPENHEIM, BERNARD, E,
 OVERLEY, TONER, MORTON,
 OWEN, JOHN, ELBA,
 OWENS, TRACY, CLIFTON,
 PALMER, ROBERT, M,
 PALMER, ROBT, W,
 PANTZER, JOHN, GEO,
 PARK, HEE, MYUNG,
 PARKER, GEO, FRANCIS,
 PARKER, JOHN, FRANCIS,
 PARKS, HERBERT, EUGENE,
 PARR, ROBT, LOWELL,
 PAUSZEK, ROBT, BRUCE,
 PAYNTER, MORRIS, BURTON,
 PAYNTER, WM, T,
 PEARCE, ROBT, MICHAEL,
 PEARSON, JACK, WILLARD,
 PEARSON, JOHN, STROTHER,
 PEARSON, LYMAN, REES,
 PECK, FRANKLIN, B,
 PECK, FRANKLIN, BRUCE,
 PEDEN, EMMA, JANE,
 PEIRCE, JAMES, D,
 PEREZ, CESAR, EDELBERTO,
 PERRIN, NELLJEAN,
 PETRANOFF, THEODORE, V,
 PETRIN, THOS, JOHN,
 PFAFF, DUDLEY, A,
 PHILLIPS, DAVID, LEE,
 PICKETT, ROBT, D,
 PIERCE, EMMETT, C,
 PILE, STAFFORD, WALLACE,
 PITTMAN, JOHN, NORMAN,
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REED, THOS, EVAN,
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RITCHEY, JAMES, OSCAR,
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RIVERA, HECTOR, P,
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ROBERTS, WARREN, CHAS,
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ROCHLIN, ISIDORE,
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ROMBERGER, FLOYD, T,
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ROSS, EDWARD,
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ROTHBAUM, DONALD, ALAN,
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ROUSHDI, HUSSEIN, ALI,
ROWE, GEO, ANTHONY,
RUDELL, KEITH, RICHARD,
RUDESILL, ROBT, LOUIS,
RUSHMORE, CHAS, HENRY,
RUSK, BARTON, JAY,
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RUSSELL, JOHN, ROBT,
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RUST, ROLAND, B,
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RYU, CHI, YOL,
SABENS, JAMES, ALBERT,
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SAGALOWSKY, HOWARD, SIDNEY,
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SALOMON, JAIME, A,
SANDERS, FRED,
SANDERS, HARRY, MUNFORD,
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SATO, TAKUYA,
SAUER, JOHN, BERNARD,
SCHAFFER, EDWARD, V,
SCHECHTER, JOHN, S,
SCHEIDLER, JAMES, A,
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SCHOEN, FREDERIC, L,
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SCHUSTER, DWIGHT, WM,
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SCOTT, IVAN, WINFIELD,
SCOTT, JOHN, RICHARD,
SCOTT, PETER, L,
SCOTT, SAML, LOGAN,
SEAMAN, CHAS, FRANCIS,
SEDAM, HERBERT, L,
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SENTANY, MARKI, S,
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SHELLEY, RICHARD, JOS,
SHERSTER, HARRY,
SHIPLEY, EDWARD, CHAS,
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SICKS, OKLA, WILBUR,
SIDERYS, HARRY,
SIEBE, JACK, CHAS,
SIGMOND, HARVEY, W,
SILBERT, ROBT, KIM,
SILVA, CARLOS, A,
SILVER, RICHARD, ARNOLD,
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SINGH, URMILA,
SINKOVIC, GERALD, MATHIAS,
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SMITH, DAVID, LESLIE,
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SMITH, JERROLD, REX,
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SMITH, ROY, LEE,
SMITH, WILBUR, L,
SNELL, MALCOLM, SHERWOOD,
SNIDER, BYRON,
SNODGRASS, ROBT, EUGENE,

SOBAT, WILLIAM, SAMUEL,
SOPER, HUNTER, ALEXANDER,
SORIA-NAVARRO, CORAZON, E,
SOTOLONGO, ELADIO,
SOULE, MARY, A,
SOUTER, MARTHA, CHANDLEY,
SOVINE, JOE, W,
SPAHR, JOHN, FRANKLIN,
SPALDING, JOS, JOHN,
SPARKS, ALAN, LEO,
SPENCE, MICHAEL, B,
SPITZBERG, DANL, HARVEY,
SPOLYAR, LOUIS, WM,
SPURGEON, CHARLES, HADDON,
SPUTH, CARL, BROSIUS,
STADLER, HAROLD, E,
STANSBURY, WM, EDWARD,
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STEELE, RONALD, EDWARD,
STEGER, BYRON, L,
STEICHEN, JAMES, BAPTISTE,
STEINKELER, STEVEN, M,
STEINMETZ, EDWARD, FRANCIS,
STEPHENS, DONALD, E,
STEURY, ERNEST, MILLARD,
STEWART, PAUL, NORFLEET,
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STOELTING, ROBT, KENNETH,
STOELTING, VERGIL, K,
STOGSDILL, WILLIS, W,
STONE, ALVIN, T,
STONE, DAVID, FRED,
STONE, WM, MAURICE,
STORER, WM, R,
STOREY, D, EDMUND,
STOUDER, ALBERT, EDWIN,
STREETER, RALPH, T,
STRICKLAND, JAMES, W,
STRICKLAND, NEIL, RICHARD,
STROUD, PAUL, E,
STUCKY, ELSWORTH, KEENE,
STUMP, LOYD, K,
STUMP, THOS, ALBERT,
SUELZER, JOHN, G,
SUESS, ROBT, EDWIN,
SULLIVAN, JAMES, JERRY,
SUMMERLIN, JACK, D,
SURRETT, MARY, A NORRIS,
SWAN, JOHN, RAYMOND,
SYMMES, ALFRED, T,
SZYNAL, JOHN, S,
TALBOTT, DAN, EUGENE,
TAUBE, JACK, I,
TAVEL, MORTON, EDWARD,
TAYLOR, CLIFFORD, C,
TAYLOR, FREDERIC, WM,
TAYLOR, HAROLD, FRANK,
TEAGUE, FRANK, W,
TEIXLER, VICTOR, A,
TEST, CHAS, EDWARD,
TETER, GEO, VINCENT,
TETHER, JOS, EDWARD,
THATCHER, HUGH, K,
THOMAN, REX, LEROY,
THOMAS, CHAS, RICHARD,
THOMAS, EDWARD, PAUL,
THOMAS, FRED, ARVILLE,
THOMAS, LOWELL, I,
THOMAS, MORRIS, E,
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THOMPSON, PAUL, DE VIZE,
THOMPSON, WAYNE, H,

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TOFAUTE, JOHN, L,
TONDRA, JOHN, MICHAEL,
TORD, JOSE, N,
TOWNLEY, NORMAND, THOS,
TRAINER, TOM, FRANK,
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TUBERGEN, LAVERNE, B,
TUCHMAN, JOS, H,
TUCKER, WARREN, SAML,
TUMULURI, V, S,
TURRELL, EUGENE, SNOW,
TUSHAN, FAYEZ, S,
TWENTY, JOHN, DOUGLAS,
TYNER, HARLAN, HOWARD,
ULLOM, RALPH, B,
VAN CAMPEN, WARREN, MILTON,
VAN FLEET, JOSEPHINE,
VAN HOEK, ROBT,
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VANDIVIER, ROBT, M,
VEATCH, RONALD, I,
VIEGAS, OSCAR, J,
VIX, VERNON, A,
VOLLRATH, VICTOR, JOHN,
VON DER HAAR, GERARD, A,
VORE, ROBT, E,
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WAKEFIELD, DONALD, LEE,
WALDO, JEANE, THAYER,
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WALTHALL, GERALD, CHAS,
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WALTON, WM, M,
WARNEKE, CHAS, HAGER,
WARNER, T, MAX,
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WARVEL, JOHN, HENRY,
WASHINGTON, WILBERT,
WASS, JUSTIN, LEO,
WATSON, STEPHEN, CLAIR,
WEAVER, DOROTHY, EMILY,
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WELLMAN, HENRY, NELSON,
WEST, JOS, L,
WESTFALL, B, KEMPER,
WHEELER, DAVID, E,
WHEELER, EDWARD, CCRNELIUS,
WHITE, CHAS, FREDRICK,
WHITE, DONALD, J,
WHITE, DOUGLAS, H,
WHITE, JOHN, B,
WIDDIFIELD, GARTH, EUGENE,
WILKENS, IRVIN, WM,
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WILLIAMS, HOWARD, S,
WILLIAMS, JAMES,
WILLIAMS, PAUL, DRAKE,
WILSON, DONALD, LEON,
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WILSON, FRED, MONROE,
WINTERS, PETER, LEE,
WIREY, HAROLD, RAY,
WISE, WM, R,
WOERNER, LAUREL, JEAN,
WOERNER, THOS, EDWIN,
WOLF, HARRY, COHEN,
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WOODARD, ABRAM, S,
WOOLFITT, ROBERT, AMOS,
WOOLLING, KENNETH, R,
WORLEY, JOS, PAUL,
WORTH, ROBT, MILTON,
WRIGHT, JOS, WM,
WRIGHT, JOS, WM,
WU, L Y, FRANK,
WURSTER, RICHARD, EDMUND,
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YACKO, MICHAEL, LOUIS,
YAW, PETER, BARNETT,
YINGLING, ROBT, JAMES,
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YOUNG, JOHN, MC CONNELL,
YOUNG, JOHN, T,
YOUNG, STEVEN, ROBT,
YUNE, HEUN, YUNG,
ZELL, EVERTSON, HYLE,
ZERFAS, CHAS, PERRY-ALLEN,
ZERFAS, PHYLLIS, K CATT,
ZIENGE, JOHN, ALAN,
ZIMMER, JOHN, FREDRICK,

MARSHALL

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CONNELL, VACTOR, O,
COURSEY, JAMES, O,
DE JESUS, JOSE, R,
DEERY, MICHAEL, FRANCIS,
FRANCE, LLOYD, CAROL,
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HOLM, BYRON, MARSH,
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KUBLEY, JAMES, DUANE,
MAC LEOD, DONALD, F,
PETERSON, RONALD, L,
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FERRARA, DONALD, WM,
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GATZIMOS, CHRISTOS, D,

GUTHRIE, JAMES, U,
HILL, LLOYD, LEON,
MALOUF, STEPHEN, DAVID,
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MONTGOMERY

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BAIRD, MALCOLM, KEITH,
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DODDS, WEMPLE,
EGGERS, RICHARD, ROY,
FOLTZ, JACK, LLOYD,
GARVISH, JOHN, FRANKLIN,
HOWLAND, CARL, BRUCE,
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KIRTLEY, JAMES, MARION,
LUDWIG, PAUL, EDWARD,
PATRON, LEONARDO, A,
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PERALTA, JOSE,
RICHARDS, EDGAR, ELVIN,
SHANNON, WESLEY, EUGENE,
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WARBINTON, FRED, PHILLIP,

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OSTHEIMER, GEO, JAMES,
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TUASON, LEONORIO, BERSAMIN,
TURNER, MAURICE, A,
VAN WIENEN, JOHN,
WILSON, OLIVER, R,
WINTER, WM, PERRY,
WITHAM, RICHARD, STEVEN,

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PARKER, JOHN, CARL,
SCHOONVELD, ARTHUR,

NOBLE

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MESSER, FRANK, WILBURN,

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STONE, ROBT, CHAS,

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HAGAN, MARION, LUTHER,
HODGIN, PHILLIP, THOS,
MC CALLA, CHAS, X,
NOFZIGER, TERRY, LEE,
SCHOOLFIELD, WM, EARL,
SPEARS, JOHN, KERN,

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ANDERSON, WM, ROBBLEE,
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BISHOP, MICHAEL, DARYL,
BOMBA, BRAD, JOS,
BOOZE, JAMES, H,
BORLAND, RAYMOND, MILTON,
BROWN, ARLIN, EDWARD,
BROWN, MARCEL, SINCLAIR,
BUCK, RODGER, LEWIS,
BUCKINGHAM, RICHARD, E,
BYRNE, DAVID, ALLEN,
CAMPBELL, WM, THOS,
COFIELD, DONALD, DEAN,
COONS, FREDERICK, WM,
CRANE, DAVID, GOODRICH,
CREEK, JEAN, A,
CRON, WM, JAMES,
CURETON, EDWARD, ERVINE,
DALTON, NAOMI, LUCILLA,
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EMERY, CHARLES, B,
FARMER, CHAS, ROBT,
FARR, JAMES, CURRY,
FERGUSON, JAMES, F,
FOWLER, RICHARD, ROSS,
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GANJI, NASSER,
GEIGER, DILLON, D,
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HOLTZMAN, PAUL, WM,
ILLMAN, DWAIN, CLARK,
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LA FOLLETTE, JAMES, WARREN,
LEE, RICHARD, V,
LEWALLEN, STEVEN, ISAAC,
LEWIS, GEO, NORWOOD,
LEY, GLEN, DAVID,
LINK, WM, C,
MACATANGAY, EDELINO, L,
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POOLITSAN, GEO, CHRIS,
PUGH, WM, ROBT,
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RAMSEY, HUGH, SMITH,
RAY, JAMES, ANTHONY,
REIMERS, ROGER, ALLEN,
REZVAN, NADER,
RICHEY, ROBT, WM,
RIEGER, IRWIN, TAYLOR,
RINK, LAWRENCE, DONALD,
ROBISON, ROGER, FRANK,
ROLLINS, THOS, K,
ROSE, ROBT, E,
ROSS, BEN, RICHARDSON,
RUFF, JERARD, GOEKE,
SCHAEFFER, JAMES, JOHANNES,
SCHECHTER, JOHN, STEPHEN,
SCHELL, HARRY, RICHARD,
SCHILLING, RICHARD, J,
SEAGLE, WM, COURTNEY,
SHAHBAHRAMI, FARROKH,
SHARP, THOS, WAYNE,
SIBBITT, JOS, WM,
SILBERT, MICHAEL, ZALMAN,
SMITH, HERSCHEL, S,
SPENCER, BEAUFORT, A,
STANGLE, WM, J,
SURIAN, MICHAEL, ANDREW,
TANNER, MARTHA, H,
TINIO, WILFRIDO, MORA,
TOPOLGUS, JAMES, N,
TOPOLGUS, JAMES, N,
WALKER, ROBT, MURRAY,
WAY, JAMES, ALFRED,
WELLS, BARBARA, D,
WENZLER, PAUL, JORDAN,
WHITE, JOHN, PHILIP,
WISEN, MARK,
WRENN, ROBT, EMMETT,

PARKE-VERMILLION

ALEXANDRESCU, GHEORGHE,
BLOOMER, RICHARD, SAML,
BRITTON, WELBON, DUNLAP,
DWYER, DANL, JOS,
EVANS, FREDERICK, J,
HARSTAD, CASPER,
HERZBERG, MILTON,
KEMPF, GERALD, FIDELIS,
MONTECILLO, ANTOLIN, M,
NICHOLAS, THOS, DAVID,
SWAIM, J, FRANKLIN,

PERRY

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GILBERT, ROBT, G,
LOHOFF, LEWIS, C,
NEIFERT, NOEL, L,
RESS, GENE, EDWIN,
SMITH, FRED,

PIKE

HALL, DONALD, LURVE,
OMSTEAD, MILTON, HARVEY,

POSEY

BOREN, PAUL, RANDOLPH,
CRIST, JOHN, R,
ROPP, HAROLD, EDWARD,
VOGEL, LAWRENCE, JOHN,
WOODS, ARBA, LEONARD,

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ARMALAVAGE, LEON, J,
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BABCOKE, GARY, ALLEN,
BARROS, PAUL, R,
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BLACK, KENNETH, A,
BLANDO, ULDARICO, BRINGAS,
BROWN, JAMES, RICHARD,
COHEN, HYMAN, LEWIS,
COVEY, THOS, JAMES,
COVINGTON, CONSTANCE, JOAN,
CRISE, JOHN, ROBT,
DAVIS, CARL, MARLOW,
DELUMPA, RUSTICA, Y CARLOS,
DELUMPA, VINCENTE, PALMA,
DITTMER, JACK, EDWARD,
DITTMER, THOS, LYLE,
DY, JAMES, T,
DY, JULEY, TEMBRINA,
EVANS, DANL, RICHARD,
FARAHMAND, FIROUZ,
FORCHETTI, JOHN, ANTHONY,
FRANK, JOHN, RAY,
GALLINATTI, JOHN, JOS,
GATES, GEO, GREGORY,
GOLD, MARVIN, E,
GORDON, JOS, LESTER,
GREEN, LEONARD, JUDSON,
GRIFFIN, CHAS, G,
GRIFFIN, JOS, PATRICK,
HALL, THOS, CHAS,
HARLESS, CLARENCE, MINOR,
HOHAM, FREDERICK, DIXON,
HOLWERDA, HARRY, LEE,
HULL, JOEL, IRVIN,
JAHNS, ALBIN, A,
KILMER, WARREN, L,
KIMMEL, LOUIS, EDMUND,
KINGMA, ROY, ELMER,
KOBAK, ALFRED, JULIAN,
KOENIG, ROBT, LOUIS,
KU, MARSHALL, JU-CHUAN,
LAI, NAN, YER,
LANDS, ROBT, MASON,
LAW, YU, HONG,
LEE, ROBT, YING,
LUCAS, OWEN, HERBERT,
MAKOVSKY, THEODORE,
MC BRIDE, J, WILLIAM,
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NIKSCH, WM, LOUIS,
O'NEILL, MARTIN, JAMES,
OLSON, L, DALE,
ONG, TIONG, GICK,

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PANGAN, ZANITA, S,
PATHEJA, SURJIT, SINGH,
PONCHER, JOHN, ROBERT,
PORACKY, BERNARD, F,
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PUTNAM

BLACK, THOS, HCUSTON,
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VEACH, RICHARD, LESTER,
VIEIRA, JOSE, THOS,
WISEMAN, EARLE, VANNOY,

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FELDMAN, MAX,
FENSTERMACHER, ROBT, EDWIN,
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FINK, JAMES, MAURICE,
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FIRESTEIN, RAY,
FISH, CLYDE, MONROE,
FISH, EDSON, CLEMENT,
FOLEY, HANSEL, ODELL,
FORREST, OTTO, NORMAN,
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FRASH, DE, VON WALTERS,
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GABRIEL, MAGDI,
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GANSER, RICHARD, A,
GARDNER, IAN, ROSS,
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GERGESHA, EDWARD, ALEX,
GERIG, ELDON, LAVERN,
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GILMAN, MARCUS, MANDLE,
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JOSEPH
 GREEN, GEO, RICHARD,
 GREEN, JAN, C,
 GREEN, NORVAL, E,
 GRILLO, DONALD,
 GRORUD, ALTON, CLAREN,
 HA, YOUNG, JAE,
 HAHN, JOHN, JOONYONG,
 HALEY, GEO, MATSON,
 HALEY, PAUL, EDWARD,
 HAMILTON, CHAS, O,
 HARDING, JOHN, SCOTT,
 HARRIS, C, GLENN,
 HARTSOUGH, RALPH, I,
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 HELMER, JOHN, FRANCIS,
 HILBERT, JOHN, W,
 HILDEBRAND, JOHN, O,
 HILL, WALLACE, CLARK,
 HILLMAN, MARION, W,
 HOLDEMAN, LILLIAN, SCHEIB,
 HOLDEMAN, RICHARD, W,
 HOLLOWAY, RICHARD, JAMES,
 HOLTZMAN, NORMAN, N,
 HORVATH, GEO, ALEXANDER,
 HOUSER, DEWARD, S,
 HOUSER, KEIM, THOS,
 HOW, LOUIS, EUGENE,
 HUNT, ROBERT, N,
 HUSSEY, LAWRENCE, KENT,
 HYDE, CARROLL, C,
 JANKOWSKI, ERNEST, BERNARD,
 JENKINS, JOHN, L,
 JIBILIAN, ARTIN, YACOB,
 KARN, JOHN, W,
 KEENAN, PATRICK, JUSTIN,
 KIM, BUM, JOO,
 KING, ROBT, PRESTON,
 KNODE, KENNETH, THOMSON,
 KRIZMAN, DAVID, JOHN,
 KRUEGER, JOHN, EDWARD,
 KUHN, FREDERICK, LEE,
 LANE, WM, HENRY,
 LAVELLE, THOS, FRANCIS,
 LEIPOLD, JON, DAVID,
 LEVATIN, BERNARD, I,
 LIONBERGER, JOHN, R,
 LISS, EMANUEL, C,
 LOCKHART, PHILIP, BRUCE,
 LUZADDER, JOHN, E,
 MAC DONELL, ELDRED, HUGH,
 MACIAS, RAFAEL,
 MACRI, PAUL, ANGELO CARL,
 MAGNUSON, CHAS, W,
 MAHANK, CAMIEL, CYRIEL,
 MARQUIS, GORDON,
 MARTIN, CHAS, F,
 MARTINOV, WM, EDWARD,
 MASON, BERNARD, A,
 MAUZY, MERRITT, C,
 MC FARLAND, CORLEY, B,
 MC MEEL, JAMES, EUGENE,
 MC QUADE, JOHN, ALLEN,
 METCALFE, GRANT, EMORY,
 MITCHELL, GARY, ALAN,
 MUELLER, HILBERT, MARTIN,
 MURPHY, JOSEPHINE, F,
 MYERS, GERALD, PAUL,
 MYERS, PHILIP, ROBT,
 NAPPER, KARL, FRANK,
 NEHER, JOHN, LEWIS,

NELSON, FRANCIS, DALE,
 NICHOLS, HAROLD, GENE,
 NORBORG, CHRISTOPHER, S,
 ODRIC, KAZIMIR, JURAJ,
 OLSON, DONALD, T,
 OLSON, KENNETH, L,
 ORR, W, ROBERT,
 PAIK, BO, WOOK,
 PAIRITZ, FRANK, DAVID,
 PARSONS, ROBT, LA RUE,
 PASCUZZI, CHRIS, A,
 PAUSZEK, THOS, B,
 PETRASS, ANDREW,
 PHELPS, STEPHEN, ROWLES,
 PLAIN, GEO,
 PLAIN, GEO, L,
 PRIMUS, ROMANA, R,
 PROUDFIT, CHAS, H,
 PYLE, HAROLD, D,
 QUINN, MICHAEL, GERALD,
 RABASA, RAFAEL,
 RASMUSSEN, RUTH, FRANCES,
 REED, ROBT, F,
 REINEKE, JAN, RICHARD,
 RICE, KATHERINE, KEMPNER,
 RICHARDS, DEAN, ALLEN,
 ROBERTS, BILLY, JOE,
 ROHRER, BRYCE, BARTON,
 ROSENHEIMER, GEO, MILTON,
 ROSENWASSER, JACOB,
 RUBENS, ELI,
 RUBUSH, JOHN, LANCE,
 SAIN, BRIAN, DAVID,
 SALAZAR, LUIS, BARBA,
 SANDERSON, ROBT, BURNS,
 SANDOCK, LOUIS, F,
 SANDOCK, MARK, STEVEN,
 SANDOZ, HARRY, H,
 SCHAPHORST, RICHARD, A,
 SCHILLER, HERBERT, A,
 SCHLOSSBERG, VICTOR, E,
 SCOTT, FRANK, M,
 SCUZZO, VINCENT, C,
 SHARP, MERLE, CALVIN,
 SHELLEY, EDWARD, S,
 SHRIBER, WM, HOWARD,
 SKILLERN, SCOTT, D,
 SMITH, LEE,
 SOBOL, ZBIGNIEW, W,
 SPALDING, DAVID, LEE,
 SPALDING, WENDELL, L,
 STAUNTON, HENRY, A,
 STIMSON, HARRY, RENNER,
 STOGDILL, WM, J,
 STRATIGOS, JOS, SPYRIDON,
 STRINGER, DRENNON, DURWOOD,
 STRYCKER, DEAN, LA MAR,
 SWEENEY, ROBT, MUROL,
 TAPLEY, DWIGHT, L,
 THOMPSON, JOHN, M,
 THOMPSON, LARRY, GENE,
 THORNTON, MAURICE, JOHN,
 TIRMAN, WALLACE, S,
 TROEGER, THOMAS, ALBERT,
 TROYER, MARLIN, L,
 TUTUNJI, NERMIN, DJAMIL,
 URRUTI, ARNOLDO, HORACIO,
 VAKKUR, GEC, JURI,
 VAN FLEIT, WM, EDMUND,
 WALERKO, FRANK,
 WALKER, EDWIN, MERCER,

WALTERS, CHAS, EDWARD,
 WARD, JAMES, WESLEY,
 WARRICK, HOMER, LYLE,
 WEHLAGE, DAVID, FRANCIS,
 WHITE, DONALD, GEO,
 WHITLOCK, MERLE, E,
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 WILSON, DOUGLAS, JAMES,
 WILSON, JAMES, M,
 WIND, JOS, LEON,
 WIXTED, JOHN, FRANCIS,
 WIXTED, JULIA, M LUNDSTROM,
 YERGLER, WILLARD, G,
 ZEIGER, IRVIN, LEWIS,

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 HENRY, HOWARD, JENNINGS,
 INGWELL, GUY, BERNARD,
 LEINBACH, EARL, R,
 MATTHEW, JOHN, ROBT,
 UFKES, HERBERT,

STEUBEN

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 DAVIS, CLAUDE, E,
 HARTMAN, JOHN, J,
 JACKSON, DEAN, B,
 KISSINGER, KNIGHT, L,
 MASON, DONALD, GOODING,
 MATTOX, DEAN, LLOYD,
 RAUSCH, NORMAN, W,
 RICHARD, NORMAN, FREDRIC,
 SCHREPFERMAN, WAYNE,
 WATKINS, LARRY, EUGENE,
 WEAVER, R, WYATT,
 YOCUM, PAUL, STONE,

SULLIVAN

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 BROWN, JOHN, STANLEY,
 CROWDER, JAMES, H,
 DAUGHERTY, WM, LOUIS,
 DUKES, BETTY, J DICKERSON,
 DUKES, JOS, ELLSWORTH,
 DUKES, RUSSELL, JAMES,
 ESKEW, KENNETH, W,
 MC CARDLE, ROBT, ALAN,
 MC CLURE, GLEN,
 SARKAR, ANIL, K,
 TAYLOR, JOHN, RICHARD,

TIPPECANOE

ADE, CHAS, HAMILTON,
 ADE, MARY, EDITH KELLER,
 ALDRICH, DAVID, DOUDT,
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BOSLEY, ROGER, EUGENE,
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BROWN, JOHN, MICHAEL,
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DAVIS, HOWARD, B,
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GUTWEIN, GILBERT,
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HANNEMANN, ROBT, EARL,
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HARVEY, BENNETT, BROWN,
HASS, CAROLINE, E HALL,
HASS, THOS, W,
HEID, GEO, J,
HORSWELL, RICHARD, R,
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HUGHES, RICHARD, R,
HULL, JAMES, EDWARD,
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KLATCH, BEN, Z,
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KNOTE, JOHN, ALTON,
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KRESLER, LEON, E,
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RADCLIFFE, LEE, EWING,
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STRAYER, JOS, WM,
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TROUT, DAVID, JOS,
UNDERWOOD, GEC, MAUZY,
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WELLER, WENDELL, A,
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WONG, NORMAN, FRANCIS,
YEGERLEHNER, FOSCOE, S,

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MEREDITH, JESSE, H,
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ALTERNATES

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11—Lloyd L. Hill, Peru	Oct. 1977
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Terms expire December 31, 1977:

Delegates: Patrick J. V. Corcoran, Evansville; Peter R. Petrich, Altica.

Alternates: Thomas C. Tyrrell, Hammond; Marvin E. Priddy, Fort Wayne.

Terms expire December 31, 1978:

Delegates: James A. Harshman, Kokomo; Malcolm O. Scamahorn, Pittsboro; Ross L. Egger, Daleville.

Alternates: George Lukemeyer, Indianapolis; Everett Bickers, Floyds Knobs; Gilbert M. Wilhelmus, Evansville.

1976-77 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
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2.	Hugh S. Ramsey, Bloomington	James P. Beck, Washington	Oct. 1-2, Clarksville
3.	Claude J. Meyer, Jeffersonville	Charles X. McCalla, Paoli	Terre Haute
4.	Larry Williams, Madison	Ott B. McAtee, Madison	Greenfield
5.	J. Franklin Swaim, Rockville	Bryon C. Wheeler	June 8, Greenwood
6.	Clarence C. Clarkson, Richmond	Hal Rhynearnson, Fortville	June 8, Muncie
7.	John M. Records, Franklin	M. O. Scamahorn, Pittsboro	
8.	Clarence M. Ashburn, Muncie	David J. Dietz, Muncie	
9.	Paul Van Kirk, W. Lafayette	Max L. Fields, Monticello	
10.	James R. Brown, Valparaiso	Barron M. F. Palmer, Hammond	
11.	William Dannacher, Wabash	Fred Poehler, La Fontaine	
12.	Thomas A. Felger, Fort Wayne	John Paul Smith, Fort Wayne	Sept. 8, Fort Wayne
13.	Elmer Billings, Elkhart	Michael G. Quinn, South Bend	Sept. 4, Elkhart

1977 ROSTER

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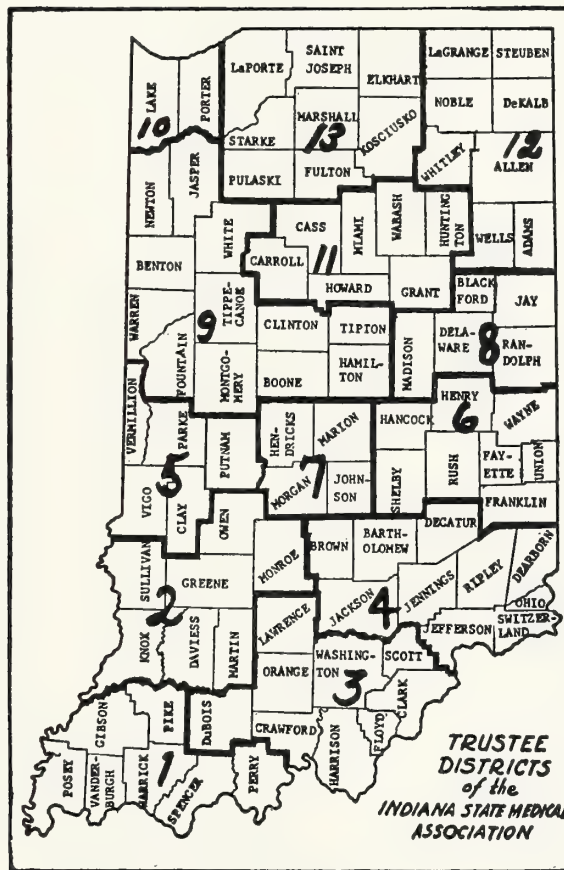
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